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Integration or isolation?: Mapping social connections and well-being amongst refugees in Glasgow

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¹<http://www.qmu.ac.uk/iimd/default.htm>

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Executive Summary

“Having all these different relationships - that helps you progress.”

(Iranian refugee participant, discussion group 3)

Government, policy makers and service providers across Scotland are committed to promoting inclusion and equality in health and well-being for the 2,400 asylum seekers and further 20,000 people with refugee status remaining in Scotland.² However, this population face multiple challenges to integration, well-being and mental health (Watters, 2001; Castles et al., 2002; Threadgold & Court, 2005; Procter, 2006; Ager & Strang, 2008; Phillimore, 2012; Quinn, 2013). Currently most asylum seekers in Scotland are single men arriving alone which leaves them very vulnerable to poor mental health exacerbated by isolation and exclusion. This study draws on the work of the ‘Sanctuary programme’ (Quinn et al., 2011) and the ‘Indicators of Integration’ study (Ager & Strang, 2008) to explore understandings of mental health and well-being and relate these to social connection amongst refugees in Glasgow.

Aims and approach of the study

The study sought to access a ‘hard-to-reach’ group: thirty single men from Iran and Afghanistan were recruited to a series of research workshops held during 2013. The workshops combined participatory activities, presentations from service providers, individual tasks and group discussions. A qualified mental health professional provided support and advice as needed. The data was collated to produce ‘maps’ of social connections indicating the spectrum of social ‘bonds’, ‘bridges’ and ‘links’³ accessed by participants, along with levels of trust and reciprocity of relationships. Systematic thematic analysis was used to capture issues emerging from group discussion on understandings of mental health and well-being.

²Scottish Government strategy: ‘New Scots: Integrating Refugees in Scotland’s Communities’, December 2013. See section 1.3 of this report for details.

³ Social Capital theory, Putnam, 2000.

Key findings

➤ Adverse Circumstances

Participants see the main threat to their mental well-being as the adverse circumstances in which they find themselves.⁴ Emphasis is placed on the impact of:

- Chronic insecurity and instability due to the asylum process and unstable housing situations.
- The experience of major life transition leading to 'culture shock'.
- Poverty creates practical problems, inhibits strategies for problem resolution and exacerbates isolation.

➤ Inactivity

These refugees and asylum seekers recognise that it is very hard to maintain mental well-being when you have, '...nothing to think about but your worries'. Solitary, sedentary occupations can help, but getting out, taking exercise and meeting friends were seen as better.

➤ Lack of intimate relationships

Most of this group rely on the phone or internet for access to family. Some are successful in developing close 'bonding' friendships ('become like brothers'), but others are not - even when they have been in Glasgow for several years.

➤ Lack of opportunity for reciprocity

Limited opportunities for reciprocal relationships lead to a sense of dependency and lack of opportunity for altruism which in itself is undermining to self-esteem and mental well-being.

➤ Developing a range of social connections

These refugees are motivated to develop a range of social connections for emotional support and also access to services. The data demonstrates that time alone is not enough to achieve a mixture of 'bonds', 'bridges' and 'links'.

➤ Awareness of services

Awareness of services is lower than might be expected – participants either did not have access to extensive informal networks, or their networks appeared to be detached from wider support services. Some use the internet to access information.

⁴ Many other studies have similarly observed that the circumstances of resettlement play at least as much, if not a more major part than pre-flight trauma in refugee mental health and well-being (e.g. Silove et al., 2000; Watters, 2010)

➤ **Trust and fear of engagement**

This group are resistant to engagement with community activities and services. They reported highest levels of trust in authority figures and lower levels of trust in third sector agencies and community organisations.

➤ **Access to Rights**

This group showed very little awareness of institutions in wider UK society, or of routes through which they might challenge decisions or quality of service provision (for example regarding housing or health care).

Recommendations

- **Address the causes of insecurity and instability, (uncertainty of asylum claims, family reunion and poverty).**
- **Provide support and accompaniment to asylum seekers and refugees in tackling practical problems.**
- **Support every asylum seeker and refugee to develop intimate and reciprocal friendships.**
- **Work through trusted people and organisations to signpost information and build engagement with wider resources and services.**

➤ **Address the causes of insecurity and instability**

- **Policy advocacy** to address delays in the asylum process, transition to new refugee status, and family reunification.
- **Minimising home moving** through enabling asylum seekers to remain in the same property on receipt of status.
- Ensure refugees have access to **sustainable housing options within 28 days** of receiving status.
- **Poverty Leadership Panel's Action Plan** to reflect the experience of asylum seekers and refugees.
- Services and community groups to build in **capacity to overcome poverty** (e.g. waiving membership or attendance fees, providing travel expenses, sharing costs).
- **Improve access and knowledge of free activities.**

➤ **Provide support and accompaniment to asylum seekers and refugees in tackling practical problems**

- Strengthen **advisory services** (Migrant Help, Glasgow's Advice and Information Network (GAIN⁵))
- Extend **peer mentoring schemes** so that a mentor is available for every person.
- Provide **immediate access to language** learning support on arrival in the country.
- Language courses to incorporate **cultural knowledge** and colloquial uses of language.
- **Training for mental health practitioners** and other front-line service providers to raise awareness of the pressures affecting asylum seekers and refugees.

➤ **Support every asylum seeker and refugee to develop intimate and reciprocal friendships**

- Language courses should strategically **support the opportunity to develop friendships.**
- **Housing providers to keep records of new refugees** to facilitate support provision.
- **Housing Officers, Concierges, and other case workers** to provide a unique link between individual refugees and community groups and services.
- Ensure every asylum seeker/refugee has access to a **one-to-one relationship** through buddying, peer mentoring or accompanying.
- Community planning partnerships should support **building relationships between** refugees and people with Scottish and other backgrounds.
- Service providers and community groups should build in opportunities for **volunteering.**

➤ **Work through trusted people and organisations to signpost information and build engagement with wider resources and services.**

- Welcome packs and other basic service information to be made **available at time of need and recognition** of relevance.
- A good quality, confidential **interpretation service** essential to ensure equitable access to services and rights.
- Policy makers and service providers should develop **clear pathways in to and out of services** based on an understanding of the integration journey.

⁵GAIN: <http://www.gain4u.org.uk/>

- **Staff training** on culturally appropriate engagement and signposting for asylum seekers and refugees.
- Key **people and places that are already trusted** should be mobilised to share information.
- Service providers to **use the internet strategically**, providing accessible information and navigation.
- Further Education Colleges to maintain and **improve access to the internet** through access to computers on-line and access to IT skills.

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“... Now we are living in the age of communication. So really people, whether it's a person or a country, they are developed by how much they are in communication with other people, whether that's...to do with jobs, economy and also mental issues. Having all these different relationships - that helps you progress.”

(Iranian refugee participant, discussion group 3)

1. Introduction

Whilst Scotland has always been a nation of immigration as well as emigration, the beginning of the 21st century has seen a dramatic increase in numbers of people seeking asylum and coming to live in Scotland as refugees. The trigger for this change has been the introduction of the 'Dispersal policy' by the UK government in 1999 which meant that for the first time asylum seekers were dispersed beyond the south east of England and around the UK including to Glasgow where the National Asylum Support Service had a contract with Glasgow City Council⁶ to house and support asylum seekers. As a result, since then the population of refugees in Scotland has been growing, formal and informal services have evolved in response, and local communities continue to adjust and change. According to recent figures there are around 2,400 asylum seekers in Scotland (Scottish Government, December 2013). In addition, the Scottish Refugee Council estimates that there could be as many as 20,000 people with refugee status who are remaining in Scotland⁷ (there is no official tracking of refugees post receiving status). Most asylum seekers arrive alone, with only around 20% arriving with other family members. Two thirds are male and one third female. Countries of origin reflect the conflict areas of the world, with the largest groups during 2012/13 coming from Pakistan, Sri Lanka, Iran, Syria, India, Bangladesh, Afghanistan, Nigeria and Albania (Home Office, 2013).

⁶ Initially the contract to house asylum seekers was with Glasgow City Council, subsequent contracts have been with the YMCA and from 2013 with SERCO.

⁷ http://www.scottishrefugeecouncil.org.uk/assets/0000/5495/4087_SRC_Referendum_Report_V3.pdf

In December 2013 a new Scottish Government strategy was launched with the stated aim of ensuring that:

“...refugees are able to build a new life from the day they arrive in Scotland and to realise their full potential with the support of mainstream services; and where they become active members of our communities with strong social relationships.” (Scottish Government, 2013 p11)

This strategy reflects a current political climate that is welcoming to inward migration, recognising both the human rights of refugees in particular, and the potential benefits to Scottish society of ‘New Scots’. Nevertheless, the aims are ambitious. There is a considerable body of literature documenting the experiences and impact of forced migration, seeking asylum and resettling which demonstrates the multiple challenges to integration, well-being and mental health that refugees face (Watters, 2001; Castles et al., 2002; Threadgold & Court, 2005; Procter, 2006; Ager & Strang, 2008; Phillimore, 2012; Quinn, 2013). Most refugees will have suffered multiple losses and are very likely to have experienced acutely distressing events before fleeing their homes. Journeys to find a place of safety are commonly so frightening and degrading, that refugees are reluctant to talk about this part of their story. On arrival, refugees experience a loss of identity and a loss of rights. They feel powerless, not only lacking in language skills and confidence, but also lacking in knowledge of how the new society works. At the same time they can be cut off from others with a similar ethnic and/or cultural background and become emotionally and socially isolated. Added to all this it has been observed that receiving countries tend to house asylum seekers in already deprived communities with poor living conditions. This only exacerbates exclusion through poverty and social deprivation (Phillimore & Goodson, 2008, Mulvey, 2010).

Given this pattern of multiple stressors it is not surprising that many asylum seekers and refugees suffer poor mental health which inhibits their progress in resettling and building their own lives in a new place. Recent work has thrown light on the extent of poor mental health amongst asylum seekers and refugees in Glasgow and also explored attitudes and understandings of mental health issues.

1.1. The Sanctuary programme

Using evidence from a participatory action research process involving over 100 asylum seekers and refugees in Scotland, the Sanctuary programme (Quinn et al., 2011) explored participants’ views on mental health problems, stigma and discrimination. The study found

that migration can have adverse effects on mental health and well-being, due to racism and the asylum process, and this is worsened by stigma and discrimination. This stigma is influenced by both social and cultural causal factors, including fear, past trauma, isolation, racism and the stress of the asylum process coupled with negative cultural beliefs about mental health problems. Refugees who were already isolated showed a lack of awareness of where to go for help and support, and a lack of trust of services and other members of the community.

The initial research was followed up with a series of 'Community Conversations' organised in collaboration with community groups⁸. Peer researchers were trained to facilitate discussions on mental health issues in order to reduce stigma, promote recovery and encourage health seeking. Participants reported benefit from joining the conversations, gaining knowledge and confidence (Quinn et al., *ibid*).

This work has highlighted the extent of mental health problems, the impact of social isolation and the benefits of bringing people together to share their experiences. These findings resonate with the 'Indicators of Integration' study which compared areas of refugee settlement in Glasgow and London and highlighted the centrality of social connections in supporting effective integration.

1.2. 'Indicators of Integration' study

Ager and Strang undertook a programme of interviews and participatory activities with refugees and settled residents to explore what made people feel 'at home' and 'settled' (Ager & Strang, 2008). The results for both groups were the same: being in relationship with other people was what mattered most. Participants valued a whole range of relationships, from the most superficial 'hello' across the street, to the need for intimate and trusted friends. They talked about the importance of accessing services and knowing that all around had equal rights. The 'Indicators of Integration' framework⁹ was developed to encompass these shared values and reflects the fact that social connections are experienced as essential to integration (Appendix 1). The framework draws on social capital theory and models of social exclusion to elaborate the types of connections that are crucial for well-being:

- **Bonds** (with people with whom I share a sense of identity) – for emotional support and the sharing of informal local knowledge

⁸ <http://www.mosaicsofmeaning.info/>

⁹ The 'Indicators of Integration' framework was developed for the UK Home Office in 2004 to provide a mechanism for shaping and evaluating policy and practice on refugee integration. Ager & Strang, 2004.
http://www.migrationscotland.org.uk/sites/smp/files/documents/indicators_of_integration.pdf

- **Bridges** (people with whom I can exchange resources) – for access to services and the exchange of resources beyond those available from other people ‘like’ me
 - **Links** (with the structures and governance of society at large) – for access to rights and contributing to the shaping of society.
- (Putnam, 1993 & Woolcock, 1998)

Along with the Sanctuary Project, this evidence on integration reinforces the significance of social connection for wellbeing. It is widely recognised that isolation directly impacts on emotional health through the lack of emotional support. However isolation also leads to a lack of local knowledge which in turn will impede access to services including general health as well as mental health services. Furthermore, this study demonstrated that insecurity of rights directly impacts well-being through engendering a sense of powerlessness and exclusion as well as impeding the receipt of appropriate resources. It can be argued that the negative impact of social isolation on mental health and well-being is likely to be cumulative as each deprivation provokes others (Strang & Ager, 2010).

1.3. Promoting mental health and well-being amongst refugees in Glasgow

It is clear that enabling refugees to ‘realise their full potential’, and ‘become active members of our communities’, with ‘strong social relationships’ is a considerable challenge. As we have seen, there are multiple factors undermining refugee and asylum seekers’ well-being and it is well documented that refugees commonly suffer poor mental health. It is likely that this will be exacerbated in areas of multiple deprivations such as North-East Glasgow, where we see a twenty-year gap in male life expectancy compared with more affluent areas of Glasgow (ScotPHO Community and Wellbeing Profiles, 2014¹⁰).

Addressing mental health and well-being is a key policy priority at international, national and local level. The World Health Organisation defines mental health and well-being as ‘a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’¹¹. The Scottish Government’s ‘Towards a Mentally Flourishing Scotland’ policy states that the ‘Scottish Government is committed to working to improve the mental health of Scotland’s people through ensuring that appropriate services are in place, but also by working through social policy and health improvement activity to

¹⁰http://www.scotpho.org.uk/opt/Reports/Profiles_2014_tech_report_v1.1.pdf

¹¹http://www.who.int/topics/mental_health/en/

reduce the burden of mental health problems and mental illness and to promote good mental wellbeing.¹² This has been taken forward in the current 'Mental Health Strategy for Scotland: 2012-2015'¹³, which brings together mental health improvement and mental health services for the first time and focuses on mental health improvement, prevention, care, services, and recovery. This emphasis on prevention within policy has been reinforced in Christie's Commission on the Future Delivery of Public Services.¹⁴

At a city level, mental health and well-being is a priority for key agencies. Glasgow City Community Health Partnership highlights in their 2013-16 Development Plan: 'work with our partners to improve the overall mental health and wellbeing of the people of Glasgow, taking forward 'No Health without Mental Health' recommendations'.¹⁵ There is also a clear commitment to addressing inequalities in health and key targets include reviewing refugee and asylum services, accessing information when homeless, access and quality of interpretation services. There is recognition that not everyone engages effectively with services and information on service provision does not always reach those in most need, such as asylum seekers and refugees. A review of health provision for asylum seekers in 2012 led to the establishment of a dedicated bridging service for asylum seekers which includes a mental health check.

NHS Greater Glasgow and Clyde are a partner in the 'Strategy for Preventing and Alleviating Homelessness in Glasgow 2009-2012'¹⁶ and have invested in a post to support Community Health Partnerships in engaging with registered social landlords to prevent homelessness and realise the potential for housing to contribute to better health and wellbeing.

Within Education Services, mental health and well-being is highlighted in the 'Curriculum for Excellence: Principles for Health and Well-being'.¹⁷ Glasgow Kelvin College highlights well-being in terms of 'developing people towards opportunity - helping them access and progress to a wider range of life enhancing opportunities and employment that best suit their needs though experience, qualifications and work'.¹⁸ Similarly Glasgow Life has as a strategic objective: 'to enhance the health and wellbeing of people who live, work and visit the City'.¹⁹

¹²<http://www.scotland.gov.uk/Publications/2009/05/06154655/2>

¹³<http://www.scotland.gov.uk/Publications/2012/08/9714>

¹⁴<http://www.scotland.gov.uk/Publications/2011/06/27154527/0>

¹⁵<http://library.nhs.uk/mediaAssets/CHP%20Glasgow/Final%20CHP%20Development%20Plan%20-%2028032013.pdf>

¹⁶<http://www.glasgow.gov.uk/CHttpHandler.ashx?id=5528&p=0>

¹⁷www.curriculumforexcellencescotland.gov.uk

¹⁸<https://www.jwheatley.ac.uk/about/>

¹⁹<http://www.glasgowlife.org.uk/about-us/Pages/Glasgow-Life-Strategic-Objectives.aspx>

Whilst there is this emphasis on mental health and well-being, there are still significant inequalities in access to services, with asylum seekers and refugees as a hard-to-reach group. Even those who are part of pre-existing groups, report isolation and demonstrate lack of awareness of services, often for various personal, social and political reasons (Mosaics of Meaning final report²⁰). Several studies conducted in Scotland have suggested that single men are particularly isolated but also underrepresented in research on refugees (Mulvey, 2013; Quinn, 2013; Ager & Strang, 2008); yet single men without family now make up around two thirds of asylum seekers in Scotland.

It is clear that multiple individual and structural and contextual factors undermine mental health and well-being for asylum seekers and refugees. This study brings together two strands of work in order to explore the resilience and resources available to isolated refugees in Glasgow by mapping their access to social connections and exploring their understandings of mental health and wellbeing:

- The Sanctuary Programme, 'Positive Mental Attitudes' team, NHS Greater Glasgow and Clyde.
- 'Indicators of Integration' research programme, Institute for International Health and Development, Queen Margaret University, Edinburgh.²¹

1.4. Objectives of study

This study set out to explore the patterns of social connection amongst refugees and asylum seekers in north and east Glasgow, and relate these patterns to their experiences of mental health and well-being and health seeking behaviour.

1.4.1. Who should we work with?

Our concern was to reach those who have been underrepresented in previous studies, and may be particularly disconnected. For this reason we decided to focus this study on single men from Afghanistan or Iran living in north and east Glasgow and of refugee origin. The majority of studies of refugees access participants through established refugee and other community groups (Ager & Strang, 2008; Mulvey, 2013; Quinn, 2013). As our interest was in exploring connectedness itself we needed to find a way of reaching people that was not already biased towards the connected. Instead we would seek to find them in collaboration with housing providers using tenant records.

²⁰ http://www.mosaicsofmeaning.info/sites/default/files/mosaics_full_research_report_0.pdf

²¹ <http://www.qmu.ac.uk/iibd/default.htm>

1.4.2. What do we need to find out?

We set out to find out about the types of social connections of which this population are aware, using the categories of 'Bonds', 'Bridges' and 'Links' (Ager & Strang, 2008). It was also important to explore the extent to which they did actually make connections with these people and organisations. Building on these notions of social capital, we measured 'reciprocity' – the opportunity to give as well as receive support – and 'trust'. Each of these is not only important for emotional well-being, but also for the maintenance of positive relationships (Putnam, 2000).

Finally, our concern was to explore the relationships between social connection and experiences of mental health and well-being amongst this group. We designed the approach to achieve the following objectives:

- 1) To provide participants with a positive experience and extend their awareness of informal and formal support available to them.
- 2) To explore
 - What are the social connections (people and organisations) that Afghan and Iranian single male refugees and asylum seekers identify as resources in achieving/maintaining good mental health and well-being whilst living in Glasgow?
 - How much do they themselves connect with these sources of help and support?
 - How much do they themselves give help and support?
 - How much do they trust in the individuals and/or organisations that they identify as potential supports?
 - How do Afghan and Iranian single male refugees and asylum seekers understand mental health and well-being, and health seeking behaviour (including access to services)?

2. Setting up the study

2.1. Support, advice and collaboration

The study was funded by the 'Positive Mental Attitudes' team of NHS Greater Glasgow and Clyde to contribute towards the goal of improving mental health and well-being for refugees and asylum seekers in the area. Our aspiration was to learn more about the social connections of our participants in order to inform service provision and community planning, as well as to provide direct support to them through the research design.

A Steering Group of refugee representatives and service providers was convened to guide the design and implementation and application of the study comprising:

- Janice (Greig) Mitchell, Health, Homelessness & Housing Lead, Glasgow City CHP
- Marie Jones & Jim Battersby, Service Improvement, Glasgow Housing Association, North East Area
- Joe Brady & Elodie Mignard, Scottish Refugee Council, Integration team
- Irene Quinn & Wendy Gormley, John Wheatley College
- Donald Lawrie, North Glasgow Integration Network
- Jackie Sunderland, Glasgow Life
- Waheed Totakhyl & Abdullah Spinger, Scottish Afghan Society
- Neil Quinn & Ruth Donnelly, Positive Mental Attitudes Team, GGC Health Board
- Alison Strang, Institute for International Health and Development, Queen Margaret University, Edinburgh.

Glasgow Housing Association (GHA), is the largest social housing provider in the area and is committed to, '*... helping Glasgow residents lead better, happier and healthier lives.*'²² This study has been undertaken in collaboration with their north and east sector teams as part of their programme to support tenants.

After data collection had been completed, a stakeholder workshop was convened to share the results of the study and explore implications for policy and practice. We are very grateful for this input and the views of stakeholders are reflected in this report. (List of contributors in Appendix 5).

²²<http://www.gha.org.uk/>

2.2. Ethical considerations

The study was designed to use participatory research methods that would not only enable us to collect information, but would also provide information and support directly to participants. Participants shared informal information about locally appropriate resources and coping strategies. Information about formal services was distributed through presentations and distribution of leaflets. We ensured that participants understood that their participation was voluntary, they could leave at any time, were not obliged to talk about anything that they did not want to, and that no information emerging from the research would be identifiable as relating to a particular person. In planning the study we recognised that some participants would be likely to be in immediate need of support. We therefore ensured that a qualified mental health professional was present throughout each research event to provide direct support and appropriate signposting.

We took advice from refugee community groups as well as our Steering Group to ensure research design was sensitive and appropriate. The research design was then approved by Queen Margaret University Research Ethics Committee²³. Before running the research events, we piloted the research methodology with members of the Scottish Afghan Society.

2.3. Recruiting participants

One of the biggest challenges was to make contact with people who are not already participating in various community groups. We are very grateful to the North East Area Service Improvement team of Glasgow Housing Association (GHA) without whom we could not have done this study. The GHA staff used tenant records to identify households indicating either Afghanistan or Iran as their country of origin. Two locations were identified as housing the highest numbers of Afghan and Iranian residents: the Townhead area near the city centre and the Pinkston Drive area in Sighthill to the north. The GHA team delivered an information sheet (Appendix 2) to all the addresses identified in these two areas as well as posting up information in the lobby areas of flats. Five to seven days later members of the research team, accompanied by a member of GHA staff and an interpreter visited each address with further information sheets translated into a selection of languages (Farsi, Dari, Pashto, and Kurdish). Visits were repeated until we had spoken to someone at the address or exhausted the possibilities of finding them (up to three times). At each address any men over the age of eighteen years who were in the UK as asylum seekers or refugees from

²³ Approval granted February 2013.

either Iran or Afghanistan (and without a wife or children in the UK) were invited to join the study.

After discussing the study (with the help of an interpreter where necessary) participants were asked to sign a consent form in their own language and invited to attend a workshop the next week. We left written information about the study and the workshop with each participant in their preferred language. In this way around 10 to 15 participants were recruited to two different workshops, one in each location, Townhead and Sighthill. In the event, of those initially agreeing to participate, 16 attended the two workshops in February 2013 (7 Sighthill, 9 Townhead).

We recognised at this point that it would not be possible to recruit more people through the tenant lists within the scope of this project. Therefore, we used data from this first phase of the study to identify contexts where Afghan and Iranian men gathered. We decided to convene two more workshops with men who were connected to existing groups. This would allow us to see if there were any differences in their patterns of connectedness or attitudes to mental health and well-being with those not recruited through groups. We approached the leadership of two groups that had been mentioned by participants: one Afghan group and one Iranian group and then met with members to explain the study (using interpreters) and invite people to participate. The study workshops were held in August 2013, between one and two weeks after meeting group representatives, at venues suggested by each of the groups. A total of 14 men participated (Iranian group: 6; Afghan group: 8).

2.4. Methods of investigation

The workshops followed an approach developed by QMU which employs participatory activities to explore the social capital of the participant group²⁴. The methodology uses sample 'real life' problems to explore connections associated with 'bonding', 'bridging' and 'linking' capital. The social connections generated in this way are relevant for participants as potential resources in their own context, and can act as a proxy indicator for their range of connections. The method does not purport to achieve a comprehensive mapping of all the connections of the group (or even one individual within it) as this would be extremely burdensome for participants. A second stage of the methodology uses these connections to develop 'connectedness' scores for individual participants and also for the social resources that the group has identified.

²⁴ QMU developed the participatory methodology in the contrasting refugee contexts of Darfur, Sudan and with asylum seekers in north Glasgow <http://qmu.adobeconnect.com/p8upcnutrae/>

Figure 1: Workshop Components

- **Participatory activity** in small groups to elicit awareness of local social connections and resources.
- Information sharing sessions by **service providers**.
- Individual **card sorting tasks** to explore individual connectedness, opportunities to give help and levels of trust.
- **Focus group discussions** on understandings of mental health and well-being.

The workshops were held in community venues familiar and local to the respective participants. Buffet lunch was provided, but no other incentives or expenses payments. A team of interpreters attended each session covering the languages of anticipated attendees at a ratio of 2:1. At each event interpreters were briefed in advance about the purpose and processes of the research (Appendix 3). Through discussion we agreed together with interpreters which words or phrases to use to express key concepts. Interpreters were requested to ensure that they translated all participant contributions verbatim, allowing the researcher to answer/ask questions for clarity.

2.4.1. The workshop programme

Registration: Participants' understanding of the information sheet was confirmed and they were invited to sign a consent form if they had not already done so. The research team recorded biographical data on age; length of time in Glasgow and UK; numbers of people living in the same residence as participant and numbers of people they had spoken to on sample days during the previous week (Appendix 4).

Welcome, introduction & demonstration of the first exercise: During the welcome we reminded participants that their participation was voluntary, they could leave at any time, were not obliged to talk about anything that they did not want to, and that no information emerging from the research would be identifiable as relating to a particular person. The researchers then demonstrated the first activity based on the example of discussing the people and organisations that were asked for help in order to set up the workshop.

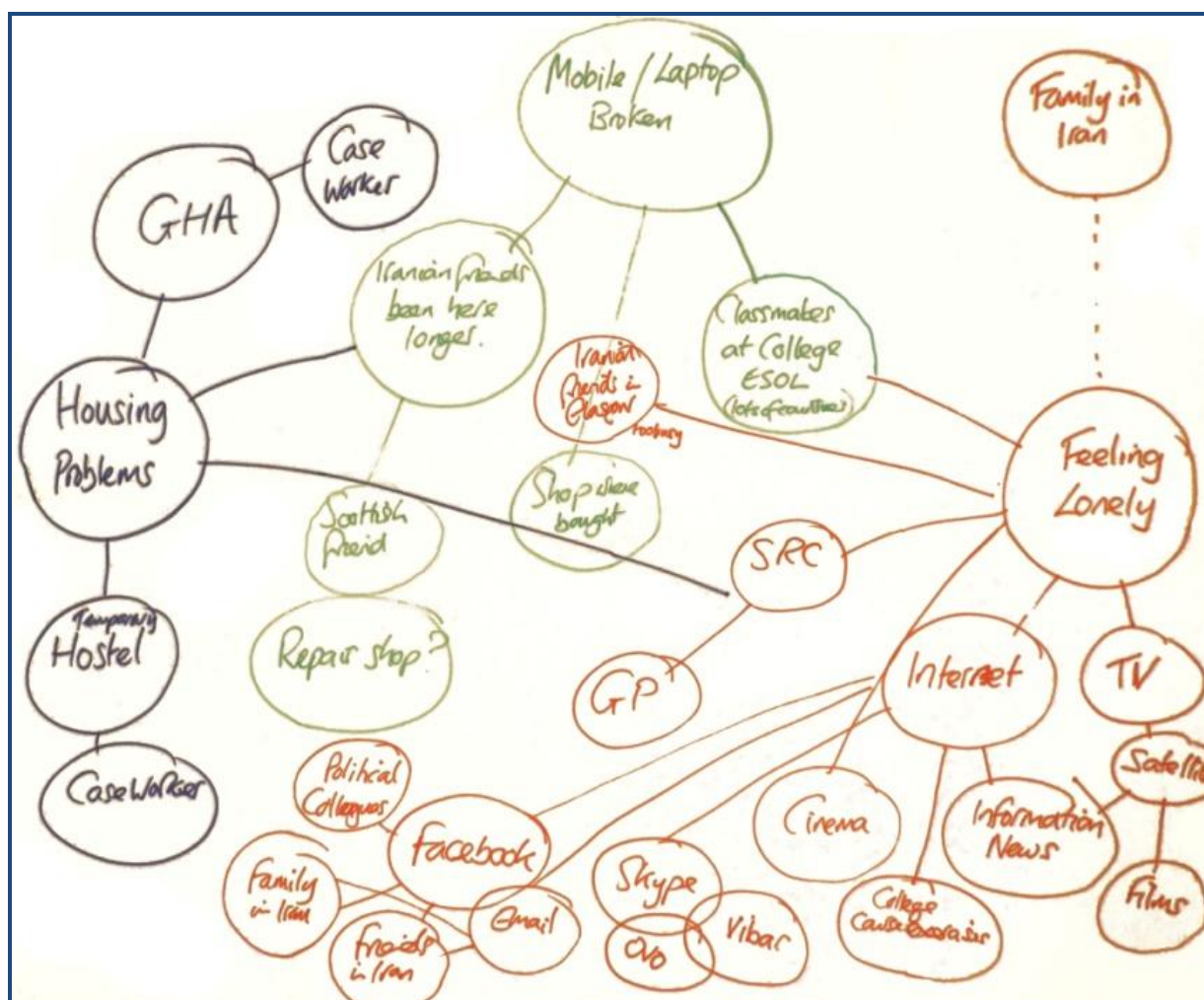
Participatory exercise: Participants were divided into small groups of up to four people (speaking the same language and/or English). One researcher (with an interpreter) facilitated each group, taking them through a series of three problems and asking them to think of all the people or organisations they might talk to, or ask for help about such a problem. Participants were then asked who each of these people (or organisations) might pass them on to if the problem could not be resolved. All the possible alternatives were explored (including people they might like to access, but are not available to them in their current lives). The three problems were chosen as familiar to the current lives and context of participants and to explore participants' access to emotional support, practical help and access to rights.

Figure 2: Problem scenarios used to elicit social connections

- *'Who would you speak to about the problem or ask for help if your computer/phone was broken?'* (Practical help)
- *'Who would you speak to about the problem or ask for help if you felt lonely?'* (Emotional support)
- *'Who would you speak to about the problem or ask for help if you had problems with your housing?'* (Practical help & Access to rights)

As discussions progressed, a researcher plotted responses on a large sheet of paper (in the middle of the table in front of participants) showing each type of person or organisation mentioned in a circle with a line linking them to the problems for which they were accessed. Where participants mentioned connections that were no longer available to them (e.g. 'Back home I would have talked to my father about that, but he has been killed, so now I can't') we included the person/organisation, but connected them with a dotted line. This process generally took about 30 – 40 minutes.

Figure 3: Sample 'map' of participants' awareness of resources



Refreshment break & Service Provider presentations: Selected services providers (GHA, 'Lifeline', John Wheatley College, 'Platform' and the Scottish Afghan Society) talked to the group about their services whilst participants were enjoying the buffet lunch. Throughout the whole event a mental health support professional from 'Lifeline' (a Glasgow based organisation providing emotional support and counselling) sat with the participants building rapport.

At the same time the research team collated the lists of social connections (people and organisations) generated by the first task - clarifying meaning, and where necessary combining items referring to the same person/organisation and reducing by excluding items mentioned by only one person.²⁵ Each item on the list was given a number and written on

²⁵We would also ensure that the list is no longer than 25 cards by excluding items mentioned by only one person, however this was not necessary as none of the groups in this study generated more than 25 social connection items.

small card. Several identical sets of cards were produced for each workshop so that several researchers could work with a participant at the same time.

Card sorting tasks: As soon as the sets of cards were ready, participants were invited individually (with the support of an interpreter as necessary) to sit apart from the group (to preserve confidentiality) and sort cards according to three questions:

Figure 4: Questions for the card sorting tasks

- *Have you spoken to or asked this person/organisation for help in the last six months?*
(Yes/No)
- *How much do you trust this person/organisation to do their best to help you – even if they don't succeed?*
(A lot/a little/not at all – illustrated by pictures showing a glass full/half full/empty)
- *In the last six months, has this person/organisation asked you to help them, or talked to you about their problems?*
(Yes/No)

Responses were recorded each time on a separate recording sheet for each participant.

Focus Group Discussions: After participants had completed the card sorting tasks they were invited to join a discussion group. One group were selected as more isolated and the other as more connected (allocated according to how connected they appeared to be from their reports of how many people they speak to each day). Both groups were led through a discussion on the following questions:

Figure 5: Focus group discussion guide questions

- *What is the first word or phrase you think of when you hear the words 'good mental health'?*
- *How do you think people would react if they knew someone was distressed, anxious or sad?*
- *If you or someone you knew was distressed, anxious or sad, who, if anyone, would they go to for help? (Prompt: for example family, friends or formal support through a doctor or a counsellor + what sort of help might they get from each of these people?)*
- *What could someone who was distressed, anxious or sad do to help themselves and make their life better?*

Discussions were recorded and transcribed and where possible an observer/researcher sat in on the session taking notes.

We ensured that all participants had a chance to talk with the 'Lifelink' representative before they left and thanked them for their contributions. At most workshops members of the team also gave particular participants further information and/or facilitated referrals to appropriate resources and services.

2.4.2. Data Analysis

The data from the participatory exercise was used to compile a collective 'map' of social connections for each of the four workshops. In each of these diagrams the particular connections mentioned by participants were plotted according to geographic proximity. Individual responses from the card sorting tasks were then used to collate levels of connection, help giving (reciprocity) and trust for each of the connections. This information was then added to the 'map' for each group.

A thematic analysis of the focus group discussion transcripts was undertaken to identify and collate participants' views on the topics discussed as well as others spontaneously emerging.

3. What we learnt

3.1. Observations from the research process

3.1.1. Accessing 'difficult-to-reach' participants

Previous studies had suggested that our target population, single refugee men from Afghanistan and Iran, was very difficult to engage in research. This was confirmed by our experiences during this study which highlighted difficulties with:

- Finding where refugees or asylum seekers from these countries lived (housing records were often not completed in detail, and many tenants had moved on due to demolitions currently underway in Glasgow. GHA had themselves recently undergone a major restructuring, and as a result we could not work with Housing Officers who would have known the tenants personally).
- Making direct contact through home addresses (people were not at home or didn't answer their door even though researchers called at different times and days).
- Converting agreement to participate into actual attendance (roughly half of the men who agreed to participate did not in fact attend the workshop to which they had been invited).

We were aware that isolated refugees and asylum seekers might well be reluctant to trust us as unknown researchers. It did seem that the fact that we were introduced by members of the GHA team lent legitimacy to our request. However, it is not surprising that for some, this was not enough to persuade them to participate in the research. Community organisations advised us, quite rightly, that it would take time to build up trust. However, for the purposes of this research it was important not to change the dynamics of social connections by building up specific relationships around a research group and in effect creating a supportive community.

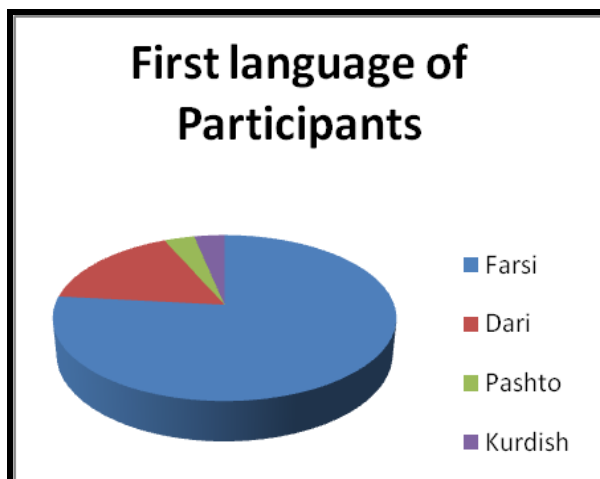
These difficulties have implications not just for the research process, but also for the general isolation of this population. A lack of engagement in research leads to an under-representation of the needs and concerns of this group in data collection and evidence. Additionally isolation and lack of engagement with anyone outside the home will inevitably reduce awareness and access to both informal support and formal support services.

3.1.2. Description of participants

We held four research workshops during 2013. Two workshops comprised Afghans or Iranians living in north east Glasgow who had been accessed through the support of GHA and door to door visits to tenants (as described above). These events were held in familiar community venues in Sighthill and Townhead respectively and participants were invited to attend whichever was most convenient. The geographic location and language profile of participants for each was similar and the data has been combined.

Participants for the third workshop were recruited through an Iranian group. The event took place in the normal meeting room of the group and of the twenty two volunteers signing up to participate, six attended and participated. Participants for the fourth workshop were recruited through an Afghan community group. By the choice of group members, this workshop was held in the Scottish Refugee Council meeting room and there were eight participants.

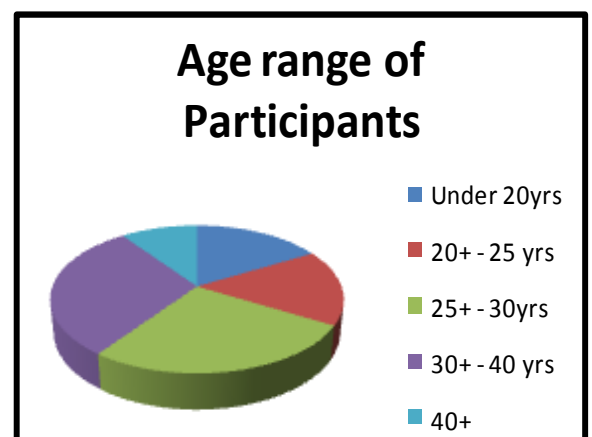
Table 1: First language of participants



Of the resulting total 30 participants in the whole study, roughly half were recruited independently of existing groups (16) and half through existing groups (14). The majority spoke Farsi as their first language ($n=23$) with a smaller group speaking Dari ($n=5$) and the remaining two speaking Pashto and Kurdish respectively.

Table 2: Age range of participants

Their ages range between 18 and over 40 years of age. The majority had been in Glasgow for over one year (17 out of 30), and of those, ten had been in Glasgow for over three years. Three had lived in the city for less than three months. The largest group lived on their own ($n=9$), seven lived with one other person, six with



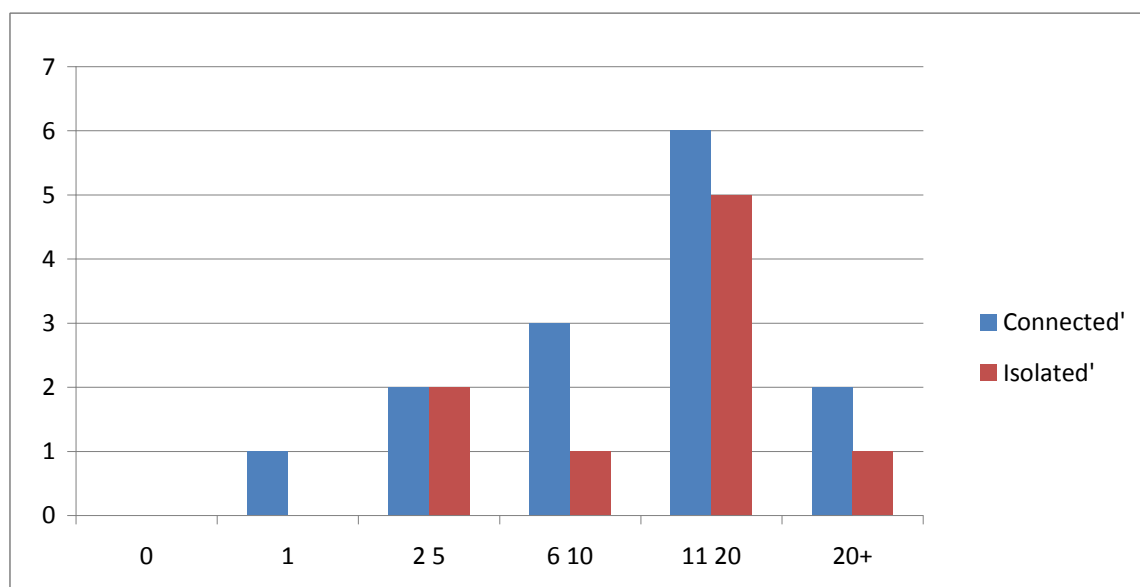
two to five people (two of whom described themselves as ‘sofa- surfing’) and two lived in a hostel for the homeless.²⁶

3.1.3. Biographical factors in relation to social connection

The number of participants in this study was small and so we have used the quantitative data simply to provide an understanding of the profile of the groups that participated in the study.

In order to gain an alternative measure of connectedness, we asked participants roughly how many people they remembered speaking to on three sample days of the previous week. Responses were used to calculate a nominal: ‘average number of people spoken to per day’. Just over half had spoken to an average of more than ten people per day on selected days in the past week (16 out of 23). Just under a third had spoken to three or less people per day (9 out of 23). This data was amalgamated for the two workshops where participants were accessed through the housing association (and were potentially very isolated) and then compared with the two workshops set up through existing community groups (who are at least a little connected).

Table 3: People spoken to each day x Connected/Isolated

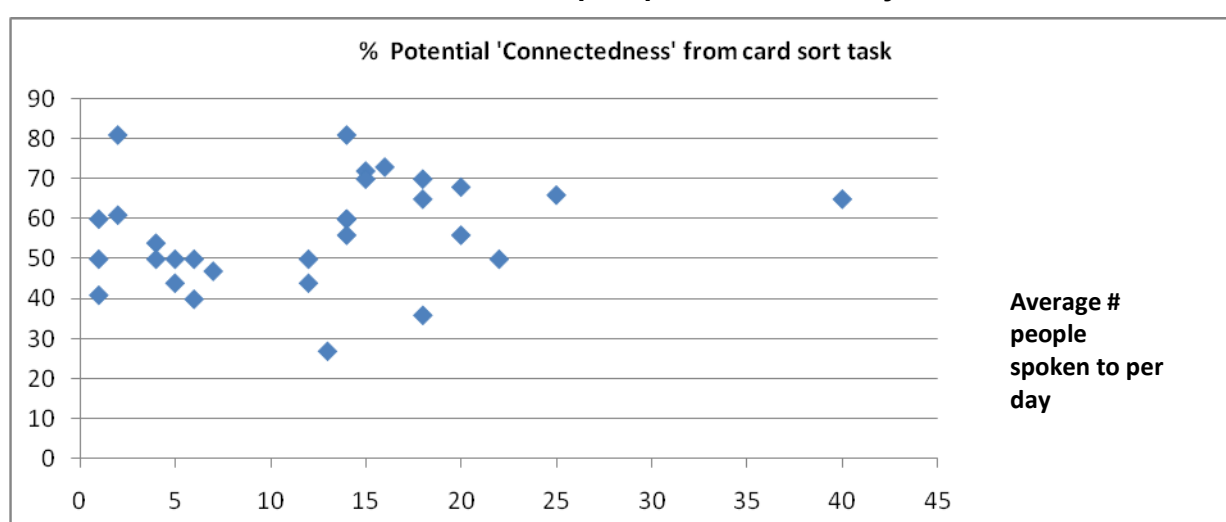


²⁶ Data on numbers living together was not available for the remaining participants.

This measure, 'Average number of people spoken to each day' is quick and easy to gather and as such is a popular measure of social isolation or connectedness in survey data. This table shows that in this cohort the distribution of daily contact scores from each group was very similar, suggesting that there was not a major difference between these two groups in terms of daily exposure to other people.

We also found that in this data, there was no clear relationship between daily exposure to other people and 'connectedness' according to our measure (derived from the participatory and card sorting exercises).

Table 4: 'Connectedness' measure x People spoken to each day



This suggests that it cannot be assumed that the numbers of daily opportunities to speak to people accurately reflects access to help and support. So for example those living in a hostel amongst twenty other homeless people may speak to a large number of people each day, but at the same time be very isolated from help at all levels, emotional, practical and access to rights. It was interesting that this was particularly true of the Afghan group who showed high levels of trust in various care givers – suggesting that they were reliant on them for emotional as well as practical support. Participants were most consistently connected with friends in Glasgow (50%+ participants had been in contact with friends in the last six months). The Afghan group was the only group where more than 50% participants reported having been in contact with family in Glasgow. Of the Iranian group, more than 50% reported having been in touch with family overseas, but there was no mention at all of family in Glasgow.

We also found that length of time spent living in Glasgow was not strongly associated with more connectedness (on either measure), nor with the opportunity to help others - suggesting that time is not enough to enable people to become connected.

3.1.4. Observations on the research workshops

Of those who did attend the research events almost all quickly became very engaged with the process, making lively contributions to the discussions. It was clear from discussions that active information sharing was going on through the participatory exercises, the stakeholder presentations and informal conversations. Some people already knew each other in advance (we encouraged people to bring their friends) but most didn't know anyone. Whilst facilitators tried to create an affirming and safe environment to encourage participation, no pressure was put on anyone to speak. In each workshop there was at least one very quiet withdrawn individual. We ensured that these participants were able to have one-to-one conversations with the support mental health professional ('Lifelink') – these conversations often revealed acute personal needs which the team followed up by putting the person in touch with the appropriate service providers. It was important to have this extra professional support as the research team were not equipped to provide appropriate mental health support and were fully utilised in facilitating the research activities.

3.2. Mapping Social Connections

The data from the participatory exercise tells us about the actual people and organisations that this population of Afghan and Iranian refugees and asylum seekers perceive as a resource for the particular problems used in the exercise. The three problems were chosen as familiar experiences for this group. We deliberately focused on emotional well-being (by asking about loneliness) and housing as these two issues were of particular interest to partners.

However the problems were also deliberately constructed to represent the three key types of relationships essential to well-being according to social capital theory, namely 'bonds' (important for emotional support), 'bridges' (important for exchange of practical help), and 'links' (important for access to rights). As a result, the range of social connections generated by the exercise can be understood as providing a representation, or proxy indication of the range of connections to which this population has access. This process was designed to be

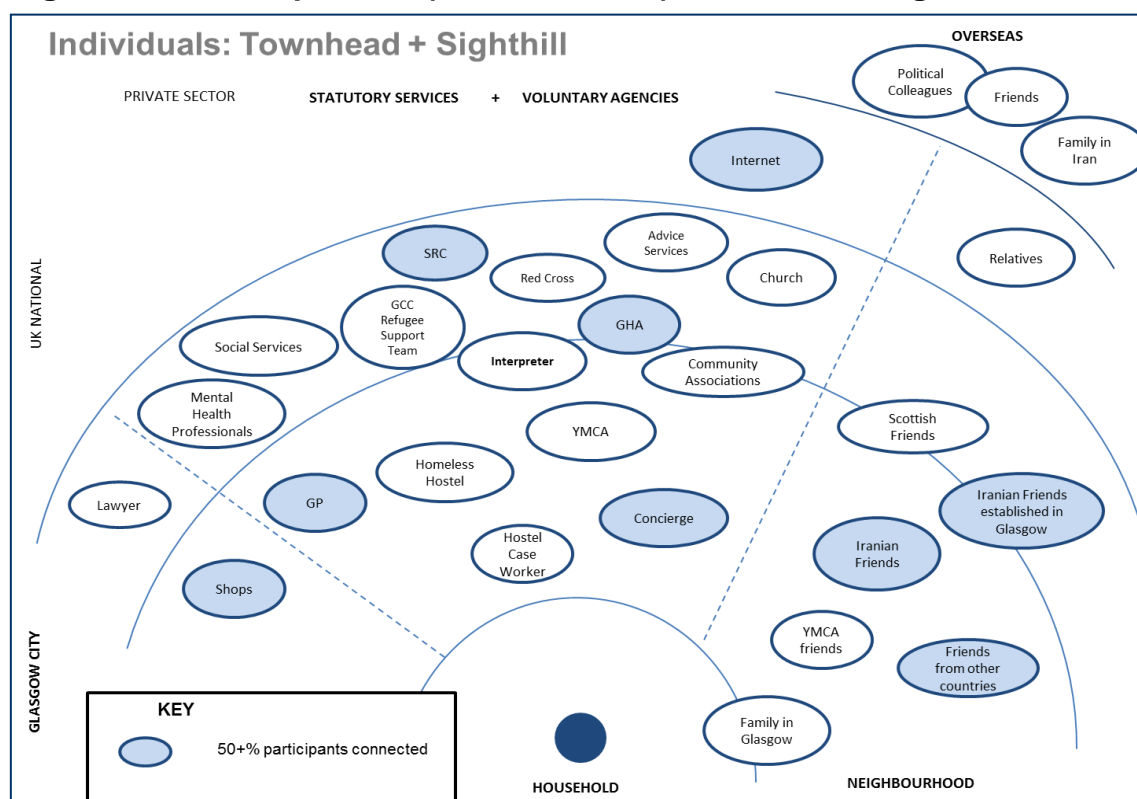
much quicker and more manageable than attempting to map every single connection for each individual.

To help to see the range of social connections available we have plotted them according to geographic proximity. (In several of the workshops this was done with the help of participants – to involve them in knowledge building as well as helping to ensure that our understanding of where people and organisations are located is correct). For ease of reading, each map also clusters social connections according to rough categories such as statutory agencies, private sector, voluntary agencies and friends and family.

These diagrams present the data emerging from the collective participatory exercise. We have then collated the individual data emerging from the card sorting tasks to superimpose findings about the levels of connection, ‘trust’ and ‘reciprocity’ (opportunities for giving help and support).

3.2.1. Awareness and Levels of Connection

Figure 6: Workshops 1 & 2 (combined data) Townhead & Sighthill



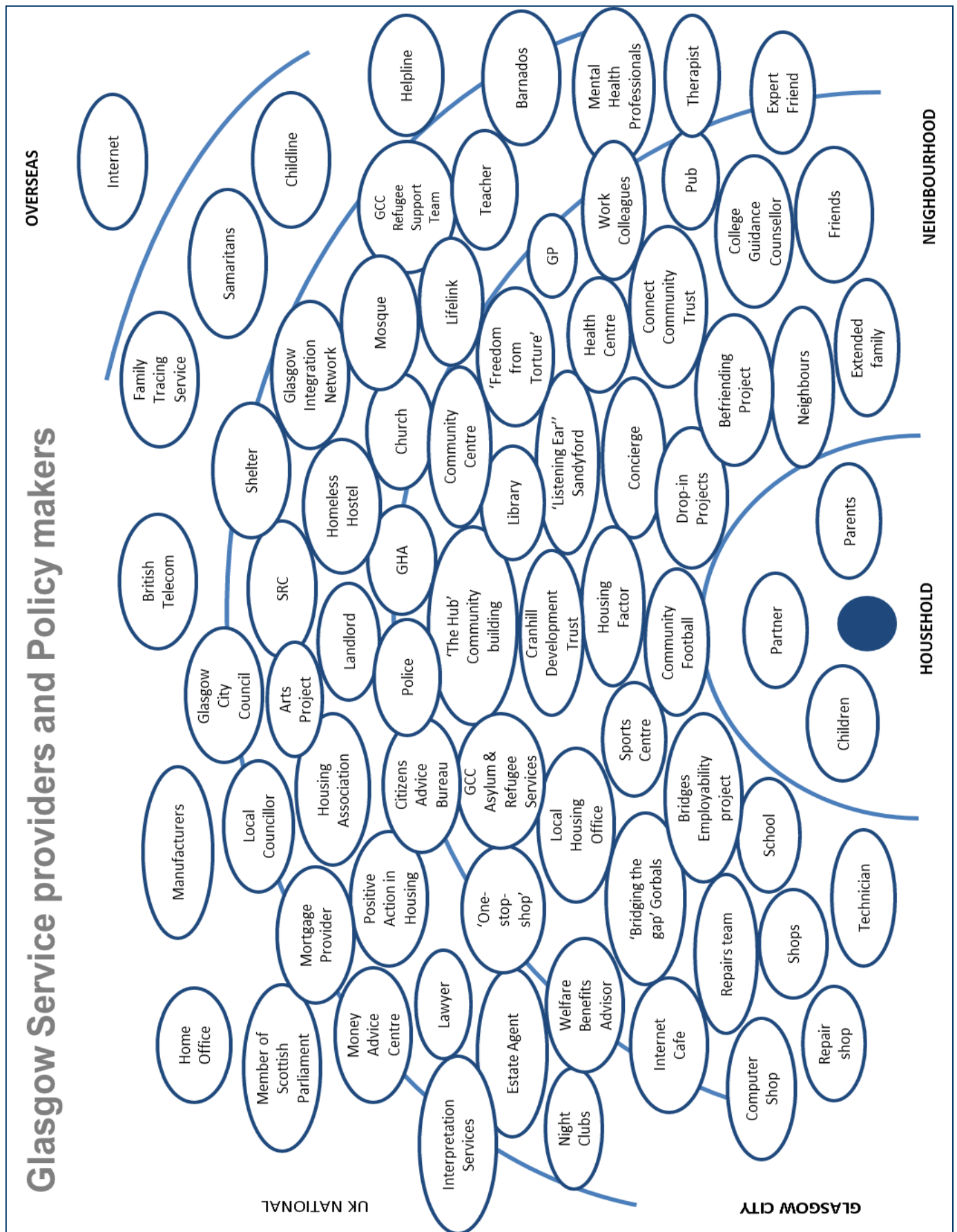
Friends & family: The data suggests that these participants lack natural bonding relationships. Most do not live with family in Glasgow. Fewer than half of the participants were in contact with family in Glasgow and fewer than half connected with family elsewhere. Some reported that they had been placed in flats with one or two other asylum seekers who they did not know beforehand. The majority reported that they currently have contact with friends in Glasgow who are from their own country and also people from other countries (these friends were likely to be other refugees as participants talked about meeting them in language classes). Fewer than half of the participants were in contact with either friends or family who were still in their home country who might be expected to provide 'bonding' relationships. This raises the question of how much new friendships in Glasgow are able to provide emotional support. This will be addressed in the presentation of the focus group discussion data. Responses showed that people from the same country of origin (or language group) that have been in Glasgow longer offer a valued resource across the spectrum of problem solving.

Local support services: In this group almost all of the rest of the connections mentioned are statutory and voluntary agency service providers, either based in the neighbourhood or Glasgow wide. However, the range is limited and does not include many of the agencies that do in fact offer support to refugees and asylum seekers (e.g. Colleges, libraries, Citizens Advice Bureau). It may indeed be that they are aware of other organisations, but it is significant in itself that these organisations are not mentioned as a resource. Participants in this group suggested that someone could go to their local doctor (GP) for help with emotional support needs, and mentioned the possibility of gaining a referral to NHS mental health professionals. However, there was no reference to any of voluntary sector mental health support – even though one of the problems was directly related to emotional well-being.

National agencies: In this map – representing the data collected from the two workshops where participants were not accessed through groups – there was no mention at all of UK national agencies that might deal with legal issues, asylum claims or access to housing or financial support. If these people are not aware of the functioning of wider Scottish and UK society, this will inhibit their independent access to rights.

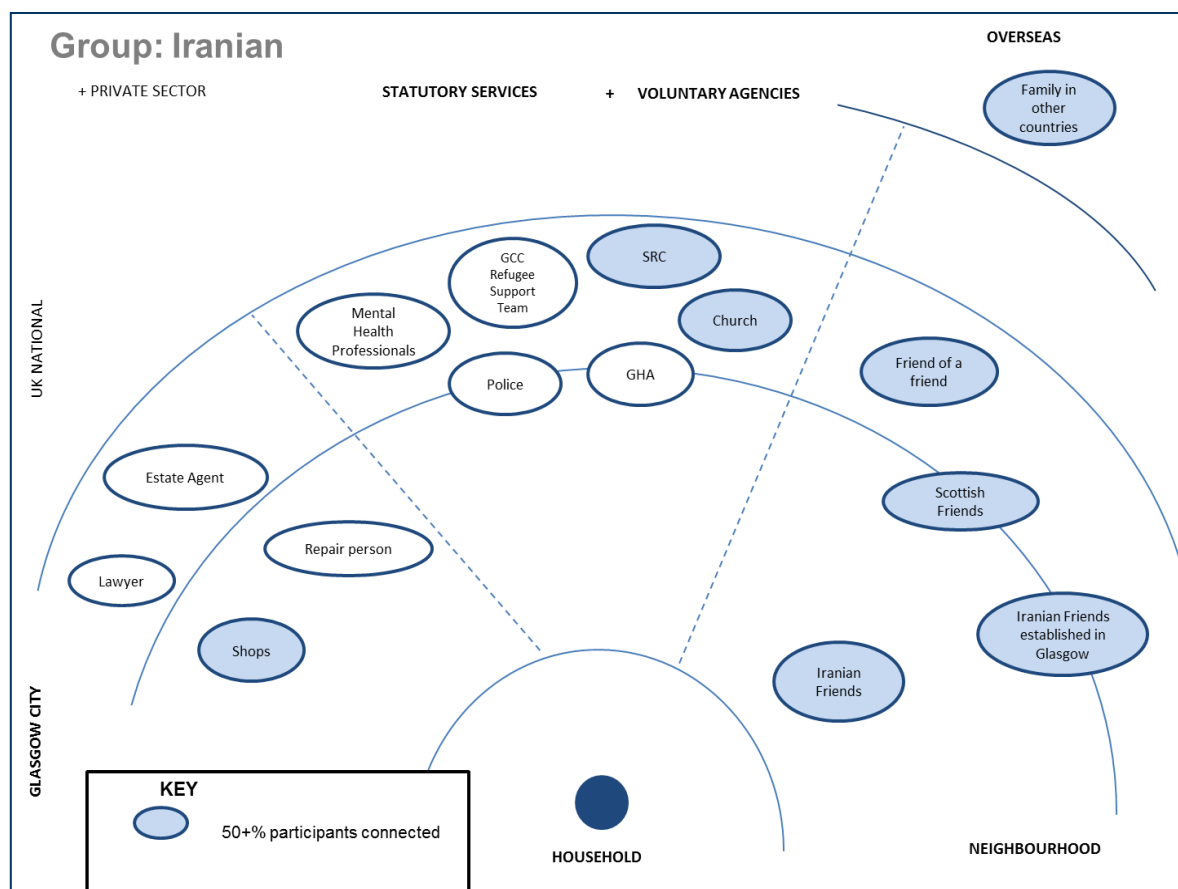
General observations: The general picture from these groups is that they have limited and patchy awareness of potential support networks. This is in stark contrast to the 'map' of potential resources generated by the contributors to our final stakeholders workshop attended by cross-sector service providers and policy makers from across Glasgow (Fig. 7).

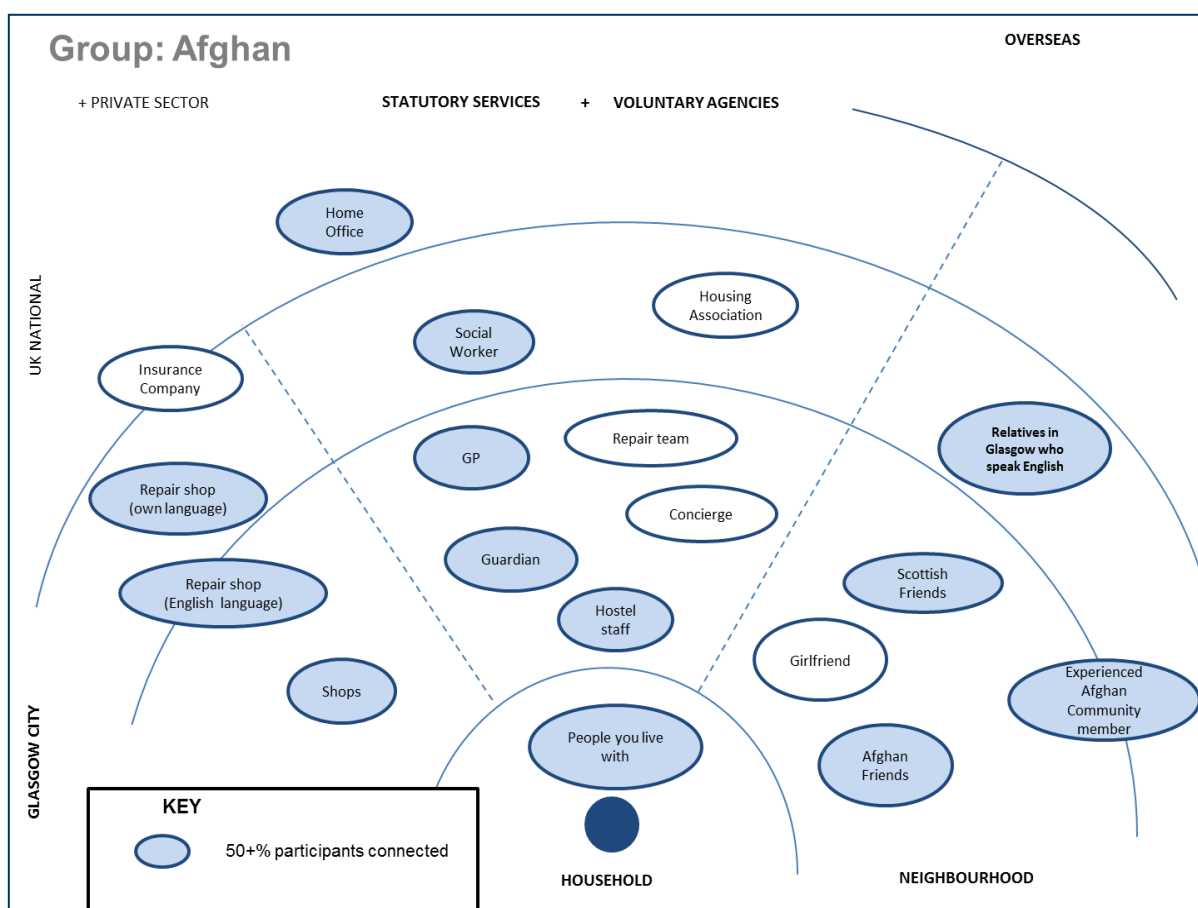
Figure 7: Glasgow Stakeholders: Social Connection



If we then look at those social resources with which at least 50% of the refugee group had been in touch over the previous six months, then the picture of access becomes even more limited. There are only nine social connections with which over half of the group had been in touch in the past six months. The picture is strongest on access to services, but very weak on access to rights or at least the awareness of routes to access rights. Participants reported that they were heavily reliant on the internet both to keep in touch with friends and family, and to finding out about resources.

Figures 8 & 9: Workshops 3 & 4, Iranian & Afghan groups





Family & Friends: Again the data for both of these groups suggests a lack of close bonding relationships. Participants reported living with other refugees or asylum seekers, a few lived in hostels and two reported that they were ‘sofa surfing’ – staying for short periods with friends. None lived with family. They reported high levels of connections with friends in Glasgow.²⁷ Again, people from their home country who are established in Glasgow are mentioned as a resource – and in both of these groups have been accessed by more than 50% of participants in the past six months. Interestingly whilst ‘Scottish friends’ were mentioned in all workshops, it was only these workshops run within pre-established groups where more than 50% of participants reported having sought the help of Scottish friends within the past six months. These two groups also talked less about friends and family from home (even though there was very little difference in the range of lengths of time participants had been in Glasgow across the different workshops).

Support services: Participants in these two workshops who were already engaged with a community group seemed to be even less aware of support services than the Townhead/Sighthill participants. This might be as a result of being dispersed across

²⁷ Apart from ‘girlfriend’ which was mentioned by one member of the Afghan group and caused great embarrassed hilarity thereafter – had the total number of connections mentioned been higher, this item would probably have been excluded as an outlier.

Glasgow rather than in areas where there are dedicated support services for refugees. In the Iranian group the only non-statutory organisations mentioned were the housing provider, GHA, the Scottish Refugee Council and the church. Once again these groups did not demonstrate awareness of most of the wider range of services in Glasgow. The members of the Afghan group made no mention of mental health professionals at all. Neither did they mention the mosque – even though, as we had already observed when meeting some of them during Ramadan, they are practising Muslims. The only non-statutory support service mentioned by this group is the housing provider. The Afghan group demonstrated relatively high levels of contact with agencies that they do mention. Over half had asked for help from case workers (hostel, guardians and social workers), their GP, and the Home Office in the past six months.

UK agencies/access to rights: With the Iranian group there was again no mention of UK national agencies. The Afghan group were the only ones to mention the Home Office.

3.2.2. Patterns of trust

Participants were asked to indicate whether they trusted each type of person or organisation ‘a lot’, ‘a little’ or ‘not at all’. Responses were then given a weighting (1-3), and total scores for each potential social connection were calculated. As participants were also given the option of not rating an item (because they did not know the organisation and so had no opinion of it, or for example: they did not have a ‘girlfriend’) a total ‘trust’ score was calculated for each item as a percentage of responses to that item. By this process all the data from the four workshops could be combined and the organisations could be ranked according to levels of trust:

Table 5: Connections ranked by ‘Trust’

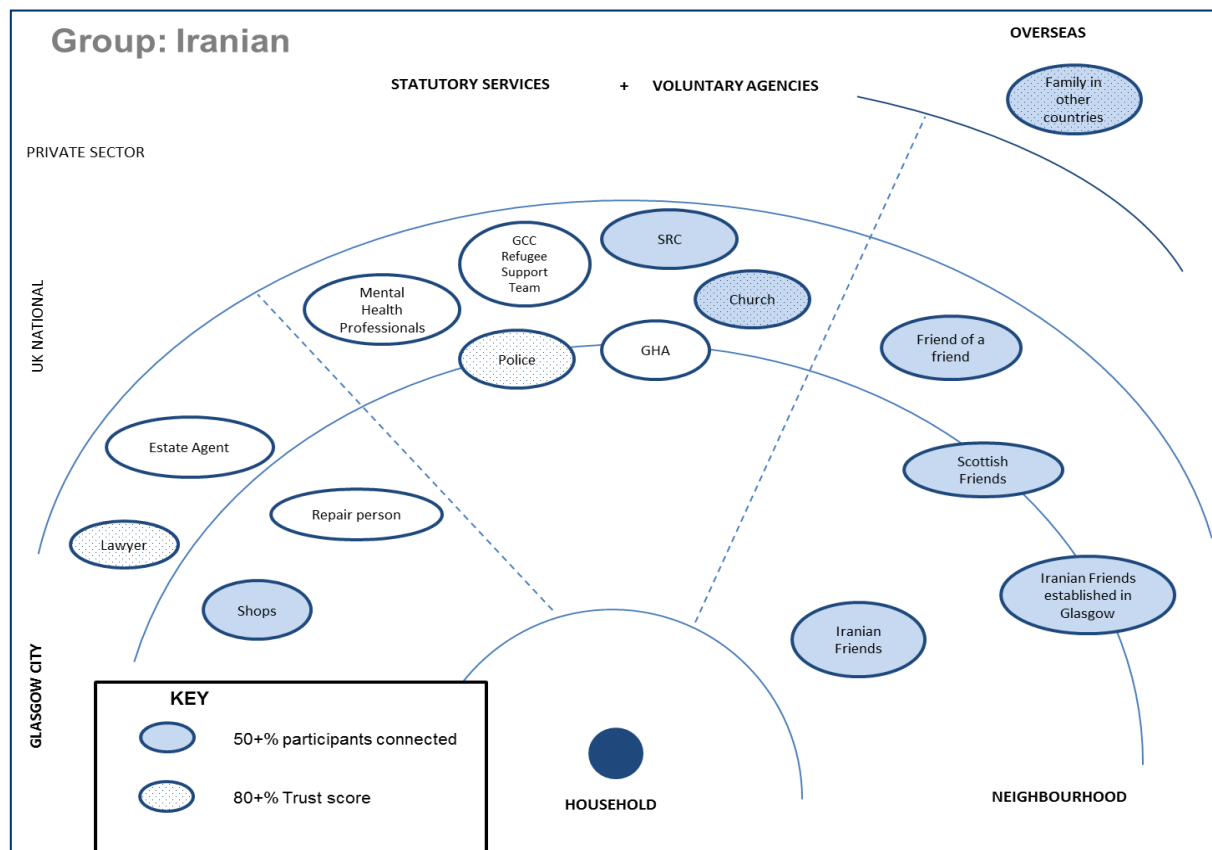
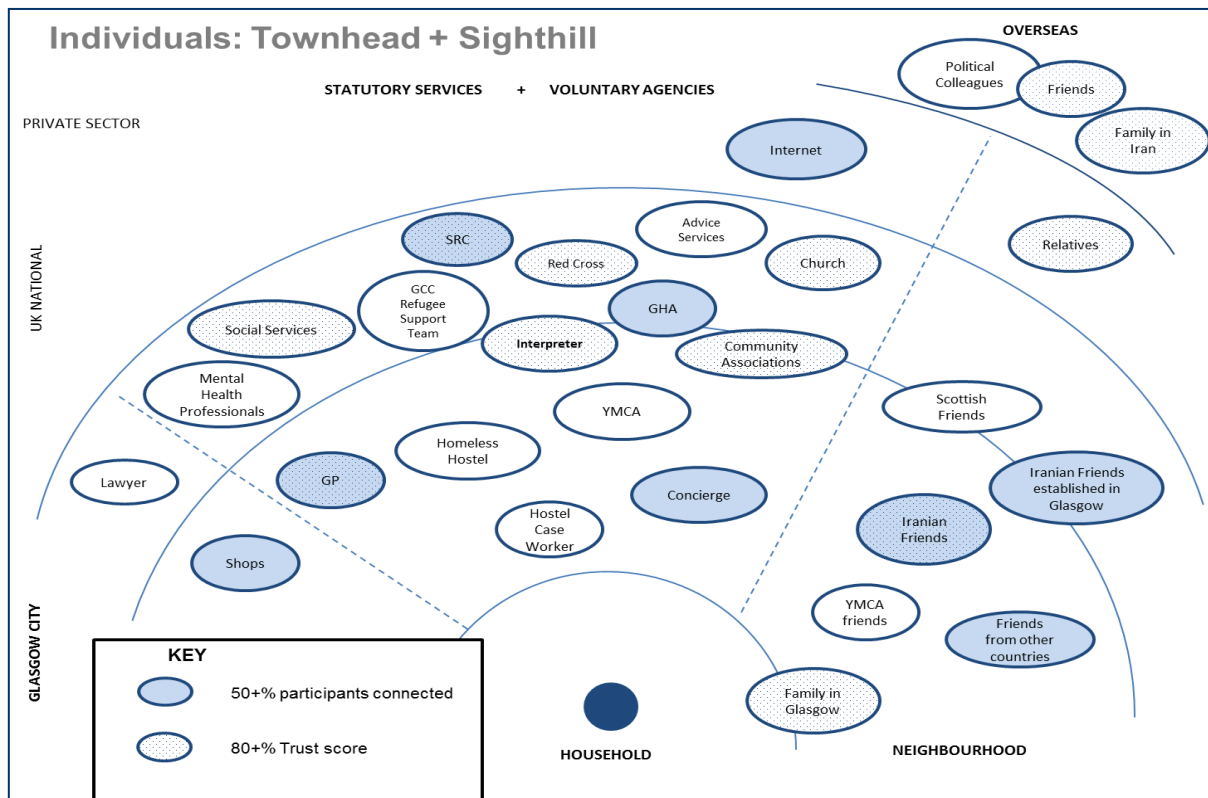
Connections	Average trust score x 3 groups
Family in home country	97
Relatives	95
Family in Glasgow	93
GP	90.5
Police	89
Interpreter	89
Guardian	89
People you live with	86
Church	86
Social Services	83.5
Community Association	83
Red Cross	83
Repair shop (own language)	83

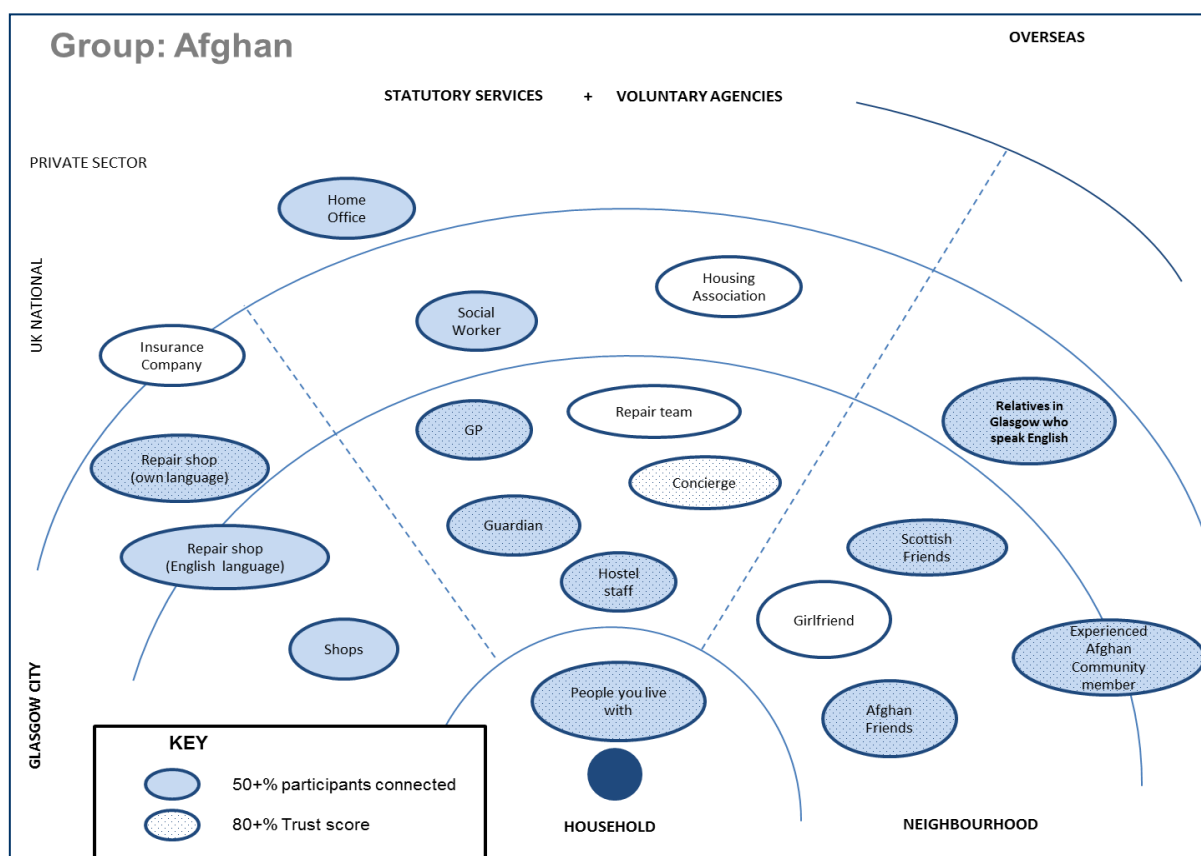
Other Iranian Glasgow-based friends	82.6
Friends Abroad	81
Lawyer	80.5
Home Office	79
Scottish friends	78.6
Concierge	78.5
Hostel Caseworker	78
Scottish Refugee Council	77
Mental Health Professional	77
Repair shop (English speaking)	75
Insurance company	75
Iranian/Afghan friends established in Glasgow	74
Girlfriend	72
Glasgow Housing Association	71
Refugee Support Team (GCC)	70
Internet	69
Friends - YMCA	67
Repair team (Housing)	67
Hamish Allen Centre (Homeless Hostel)	65
ESOL Classmates + Friends other countries	62.5
Shops	60
Friends - Glasgow	60
Advice Services	58
Political Colleagues (home country)	56
YMCA	39
Estate Agent	33

We can see from this table that 'family' is consistently ranked highest in 'trust'. The next highest ranking connection is the local doctor (GP), closely followed by the Police, interpreters and Guardians. Familiar organisations and services and also different categories of friends showed more variability in scores and this is reflected in their middle ranking positions. People tended to trust those from their own country most.

We can see that there was a tendency to report fairly high levels of 'trust' – with all but two of the average 'trust' scores for each connection above 56%. (Therefore in order to achieve meaningful differentiation for the data plotted on the map a cut-off point of 80% was used for the 'trust' score.) This seems high, especially for a group of people whom it might be expected would have learnt not to trust other people and organisations as a result of their pre-flight and journey experiences. As seen above, after 'family' the highest level of trust (which reflects consistently high rankings across participants) was associated with GPs, closely followed by Police. This may or may not show genuine confidence in the UK state sector. It may reflect that participants feel the need to show respect for authority in the research context (which is often perceived as 'official'). The Afghan community group also indicated higher levels of trust in people who could be said to have a 'carer' (or case worker) relationship with them such as their GP, Guardian, Hostel staff, or the housing Concierge.

Figures 10, 11 & 12: Patterns of 'Trust'





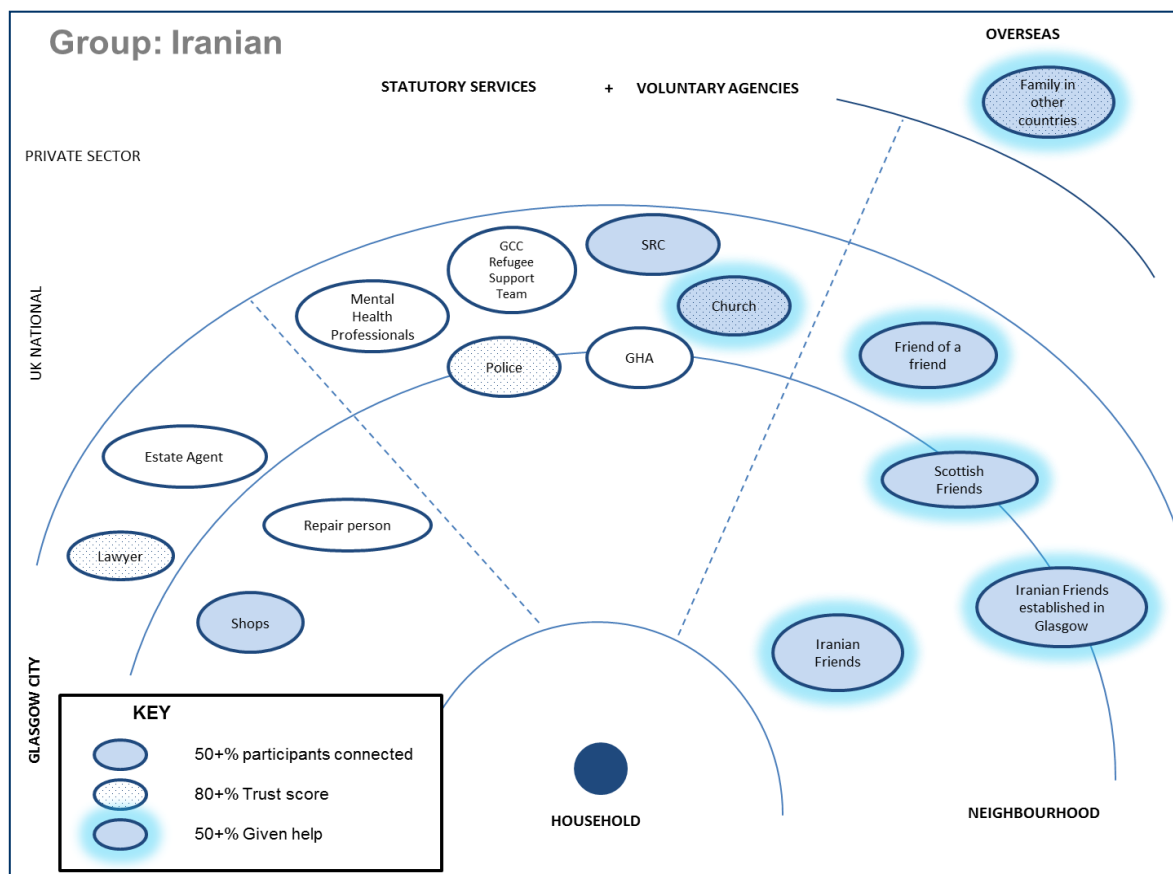
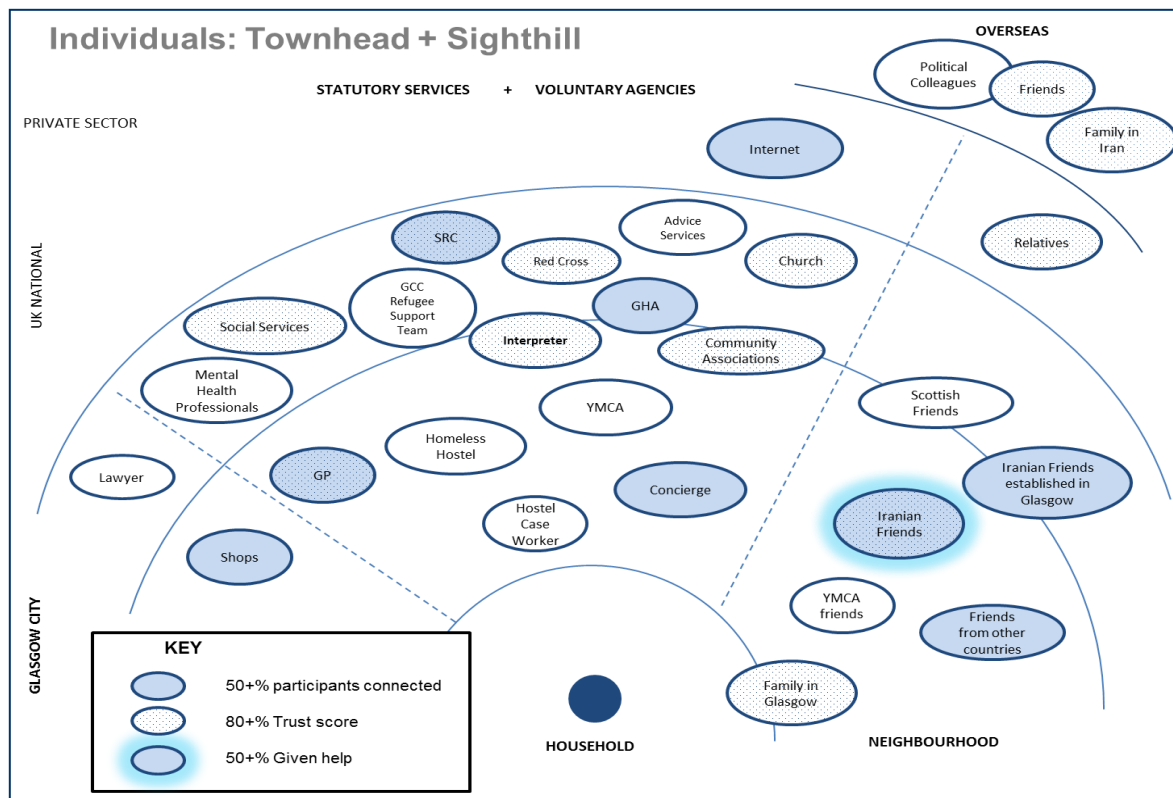
Responses to the cards relating to family and friends showed much greater variation, with participants often very confident and more extreme in their judgements from 'a lot' to 'not at all'.

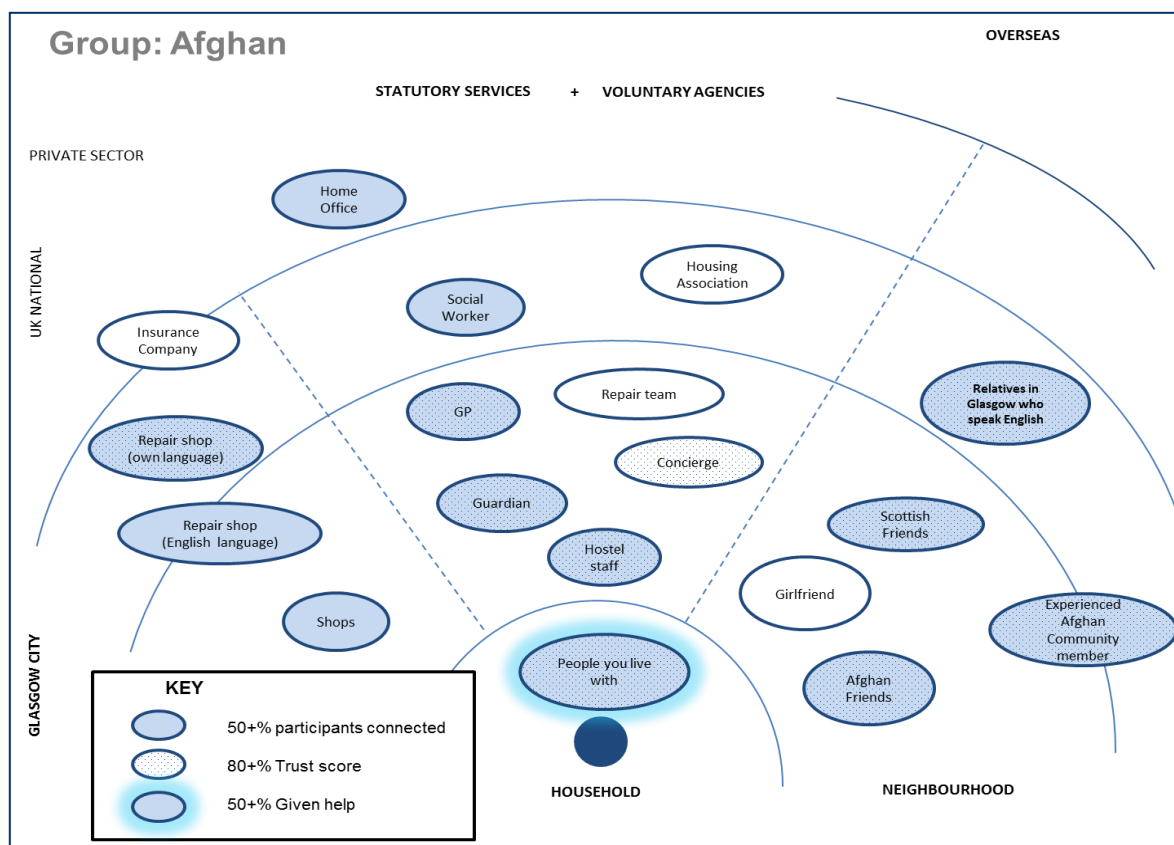
Whilst participants' reactions and the resulting data suggest that this task was meaningful to participants, it did not allow for any exploration of the basis for these judgements. Often participants wanted to talk more about this which suggests that in future the task could be used to prompt discussion and explore issues of trust further.

3.2.3. Opportunities for reciprocity

The final maps add information on the extent to which participants reported that they had been asked for help by others, or talked to others about their own problems. The card sorting task simply asked for a 'yes' or 'no' answer so does not purport to reflect degrees in the extent to which the participant has given support to different areas of their social connections.

Figures 13, 14 & 15: Opportunities for reciprocity





It is very striking in both the Sighthill/Townhead and Afghan group data how little opportunity these participants have had for giving help. In both data sets the participants demonstrate that they only have one type of relationship where at least half of participants have been able to support or give help. The Sighthill/Townhead participants reported giving help to Glasgow based friends who are from the same county of origin. The Afghan group reported that they were only able to reciprocate by helping those with whom they were living. In contrast, the Iranian group report that they have had opportunities to help friends, family overseas and others in the group. They are also the only group who have higher levels of contact – and opportunities for reciprocal relationships with Scottish friends.

Putnam has argued powerfully that the exercise of reciprocal help-giving and receiving is fundamental to the development and maintenance of social capital and in turn a community where resources are shared and used to the full (Putnam, 2000). This data suggests that most participants are largely excluded from the opportunity to share. Furthermore, others have argued that altruism in itself is beneficial to mental health and well-being (Mental Health Foundation, 2012). Most participants in this study appear to have very limited opportunity to experience the benefits of giving to others – this is likely to be undermining to their mental health and well-being (Green, 2006; Quinn, 2013).

3.2.4. Observations on access to services

Participants mentioned very few resources for dealing with mental health issues, despite the fact that we specifically explored mental health issues by choosing the example of 'feeling sad and lonely'. It is clear that this group are:

- Generally lacking in access to family support
- Often living alone or with people they don't know
- Aware of the potential help offered by a GP
- Not aware of counselling services or specialist psychiatric care

However, they did not even mention – let alone report that they had been in contact with – many of the support agencies and other resources that would be available (as illustrated by the 'map' produced by stakeholders, Figure 7). Similarly there was very little evidence of awareness of processes by which they might ensure services are delivered to an appropriate standard or access their rights (such as Members of Parliament, Members of the Scottish Parliament, Councillors, Courts, Ombudsman, Citizens Advice Bureau).

It could be argued that whilst participants from the Iranian group have access to a good network of personal connections, they are much weaker in their access to relevant services. On the other hand, members of the Afghan group appear to be more aware of services but more personally isolated.

This study was not set up to explore the role of the internet in making social connections. However, participants spontaneously talked about the various ways in which they used the internet both to keep in touch with family and friends, and also to find out information. It appears that these isolated refugees and asylum seekers are very dependent on the internet for access to both personal relationships and services. This suggests that improving access to and proficiency with information technology might support this group. At the same time, as will be discussed below, participants themselves suggested that spending too much time on the computer could act as an inhibitor to engaging with the challenges of their lives and to connecting with the people of Glasgow.

3.3. Focus Group Discussions

The focus group discussions were designed to build on the work of the Sanctuary project by exploring the same issues with this isolated group of refugees hitherto under-represented. So the following discussion questions were used:

- What is the first word or phrase you think of when you hear the words 'good mental health'? (Prompt: or 'well-being'?)
- How do you think people would react if they knew someone was distressed, anxious or sad?
- If you or someone you knew was distressed, anxious or sad, who, if anyone, would they go to for help? (Prompt: for example family, friends or formal support through a doctor or a counsellor + what sort of help might they get from each of these people?)
- What could someone who was distressed, anxious or sad do to help themselves and make their life better?

Participants were divided into smaller groups on the basis of their responses to the questions about numbers of people they had spoken to each day (because the information on 'connectedness' according to our participatory methodology was not available until analysed after the workshop). However, as our subsequent analysis suggests that this is not a robust indicator of connectedness, we have not separated out isolated/connected in the analysis of the focus group discussion data.

3.3.1. Understandings of the term 'good mental health'

Feelings& symptoms

Good mental health and well-being was seen by many participants as associated with a feeling of 'happiness'. Most elaborated this in terms of circumstances. One person suggested that good mental health is directly dependent on circumstances, 'Good mental health is the absence of problems' (gp5). However most others suggested that it depends on the way you feel about your circumstances. For example: '... you know what you are doing, when you think of your life situation you are happy again' (gp3); 'a stress-free life' (gp1). Another participant linked good mental health with optimism and hopefulness about the future (gp3). Participants suggested that there are two key circumstantial factors that underpin good mental health. One is the absence of uncertainty (gps 3&5) and the other a 'sense of safety' (gp2).

Interestingly, although we did not ask about *poor* mental health, participants were very quick to move on to talking about poor mental health and seemed to find it easier to talk about this. They had a variety of constructs to use to describe the feelings associated with poor mental health: 'depressed'; 'vulnerable'; 'lonely'; 'stressed'. Poor mental health was sometimes physically located inside the body: 'a problem in the head' (gp6), or '...something wrong inside me' (gp7). Participants also talked about symptoms, mentioning that poor mental health is associated with sleep problems and other health problems.

Behavioural impacts

The discussions showed very clearly that participants generally believe that mental health, be it good or poor has a significant impact on an individual's approach to life and to their behaviour.

On the positive side, for some, good mental health was associated with, and perhaps even defined by, the ability to solve life's problems:

'Basically the problems, issues...always it goes through their life. But with me, the good mental health is a problem I can sort out. If I have a problem I can't sort out, that is bad mental health'

'In my opinion, almost everybody got a problem, but main issue is how we can manage to sort out problems – that's very important.' (gp5)

People with good mental health are seen as able to work, participate in opportunities such as education and live healthily. They were also seen as being able to form good relationships with people and with God. People with good mental health can contribute to society:

'He can serve himself well, he can help the community.' (gp6)

In direct contrast, participants observed that people with poor mental health do not have much contact with others. Sometimes they choose to be alone (gp5). However it was also suggested that this isolation is sometimes because people with poor mental health often behave in ways unacceptable to others. Unacceptable behaviour included 'saying unacceptable things' (gp6), and also 'doing stuff you are not supposed to be doing for example, smoking or going out, misbehaving' (gp3). This data points to the view that people become marginalised and isolated because their behaviour falls outside accepted social norms.

Causes

Much of the discussion about what was understood by good mental health gave insights into how participants viewed the underlying causes of mental health problems. The dominant themes were:

- Insecurity of circumstances
- Social isolation
- 'Culture shock'
- Poverty
- Inactivity

A strong consensus emerged that insecurity of circumstances is the obvious cause of mental health problems amongst asylum seekers and refugees. Participants frequently mentioned uncertainty about immigration status and the asylum process and some mentioned insecurity of housing tenure. Several also talked about the impact of uncertainty about the well-being of loved ones in their home country and of the general circumstances in their home country. One person mentioned how upsetting it is when you are worrying about your family back home, but people in the UK don't accept the truth of what you are saying. (gp5)

The second dominant theme, social isolation, was again often introduced as an obvious cause of poor mental health:

'A person who is alone, they don't have contact... You become depressed straight away' (gp4)

Social isolation was mentioned as a cause of poor mental health in all the discussion groups. It was seen as resulting from homesickness and being away from family and friends:

'For the last three years I am here for every occasion, even New Year or whatever, nobody calls me!'

Participants felt isolated by their lack of familiarity with the local language and culture. One in particular talked movingly about the disempowering and deskilling effect of this total unfamiliarity:

'On arriving in UK I was in total shock. I didn't know what to do; didn't know the language and didn't know the culture. I felt like a new born baby who can't do anything.' (gp4)

Others pointed out that poverty often directly prevents refugees or asylum seekers from attending community events, the Mosque and so on, thus impeding their ability to make new social connections. As we saw earlier, participants also recognised that social isolation can sometime result from poor mental health, thereby creating a vicious cycle.

The final recurring theme was that of being under-occupied. Several participants pointed out that poor mental health is both provoked and exacerbated by not having enough things to do:

‘I think most of the worries occur when you’ve got nothing to do, you know when you don’t have, you know (...) from boredom, you don’t have nothing to do so you start worrying about things.” (gp1)

People felt that the circumstances of the asylum seeker who has a roof over their heads, but no right to work and not enough money to go out and join in groups and activities leads to the development of mental health problems. A number of different participants talked about the experience of having nothing to look at but the ‘four walls’ of their flat, and nothing to do but think about their problems.

3.3.2. How do other people react?

The Sanctuary project had revealed high levels of stigma associated with poor mental health by refugees and asylum seekers. This study therefore deliberately set out to explore attitudes to those experiencing mental health problems by asking: How do you think people would react if they know someone was distressed, anxious or sad?

The responses of participants in every discussion group in this study suggested that they themselves would be sympathetic and expect to help others with poor mental health. Some expressed solidarity in very strong terms, for example:

‘If you don’t sympathise with others how can you be called a human?’ (gp2)

There was general agreement that in their own country and culture it would be the responsibility of the family to support those who were ‘distressed, anxious or sad’²⁸. However, the particular circumstances of being an asylum seeker or refugee, away from close family, meant that they formed much closer friendships (usually with others from their own country). It is through these friendships that they give and receive emotional support in Glasgow.

²⁸ This is confirmed by other studies on Afghan and Iranian culture – for example in Cardozo, B., O. Bilukha, et al. (2004).

Participants also admitted that in the community at large, people might avoid someone with a mental health problem. So it might be possible that they were simply reluctant to attribute to themselves attitudes which they saw as negative. However, this interpretation was not borne out by other parts of the discussion data. It was apparent from the very concrete and lively way that participants discussed the topic that they were talking from experience of supporting one another rather than in the abstract. (The ways in which this group provided support will be discussed in the next section.)

Finally, in several discussions participants argued that there were certain circumstances when neither they themselves nor other members of the community would attempt to get involved in helping someone with mental health problems. These circumstances were very specific: if someone had committed a serious crime, were alcohol or drug addicts, or if you were struggling with the same problem yourself. The argument for not getting involved in the case of alcohol and drug addiction was that it is very difficult for family and friends to actually help, and a professional is needed with these problems. The reason for avoiding someone with problems similar to yourself was that you might not be strong enough to support them and might both make each other worse.

3.3.3. Sources of help

The discussions then probed sources of help known to participants, and how these sources were perceived.

As was established in the last section, there was clear agreement that participants considered that family would normally be the first source of help to turn to for people who have poor mental health. However, it was also universally accepted that family were not available to refugees and asylum seekers like themselves and from their own background who were now in Glasgow. Discussions explored access to both formal services and to the informal support of friends. These participants demonstrated a limited awareness of formal support services and chose to focus on the strategies that friends use to support one another.

Formal Support services

Most groups mentioned that people who were 'distressed, anxious or sad' could go to their local doctor (GP) for help. They understood that the GP can then refer patients to specialist

treatment including for mental health. Health services were seen as good, but slow to access. Two different participants quoted examples of long waits for appointments and/or treatment. One participant related an alarming story:

‘On one of the cases someone was approaching the hospital to give him a tablet and they didn’t. And eventually he was so annoyed... cos it took a while to prescribe him... he went to the hospital and set himself on fire.’
(gp1)

Another participant suggested that some people may be reluctant to seek professional help because they do not know the ‘terms’ to use. (gp5)

There was no spontaneous mention of any voluntary sector services available for mental health support in Glasgow in any of the discussions. One participant claimed that there are no organisations in Glasgow to help people suffering from distress or anxiety. Several commented that they knew very little about existing services, such as the ‘Lifelink’ organisation represented at the research workshops. Participants asked for more information and that it should be provided in their own languages.

When talking about how to find out about support services, some said that they would normally seek information from family and friends. It was in the absence of family/friendship networks that a number of participants would seek information on the internet. One participant implied that accessing information through the internet was attractive because it was private.

In addition to medical services, participants also suggested that people who are ‘distressed, anxious or sad’ might seek help from other professionals who are able to help them with the circumstantial difficulties seen as the cause of their mental health problems. In this context they mentioned seeking help from a lawyer or the Citizens Advice Bureau, or potentially a hostel case worker or Community Association.

Informal support

‘I’ve never been to an official organisation but I go to people I know or friends and they’ve generally been able to help.’ (gp3)

The data consistently demonstrates that friends are seen as the primary source of help for anyone who is ‘distressed, anxious or sad’. Participants generally argued that they would not expect to share personal issues with all friends, but would have a small number of very

trusted friends, 'Not every friend, but one or two friends who you are close to.' (gp3). As a result of this sharing, these friends would become like substitute family:

'Because you haven't got family in Glasgow, you share with friends, and become like brothers.' (gp2)

Other people did also talk about going to friends, neighbours and Scottish friends for help. Participants were able to specify various ways in which friends are able to help:

- 'Talk to them and find out what is wrong' (gp7)
- 'Cheer you up' (gp3)
- 'Reassure them' (gp7)
- 'Give advice' (gps1,3&7)
- 'Give information'(gp1)
- 'Befriend them, take them out somewhere' (gp7)
- 'Take you out to have some fun' (gp3)
- 'Take them out for a walk' (gp7)

This list illustrates a very constructive range of types of help including listening, encouragement, advice-giving, befriending and distracting. There was a level of detail across the different group discussions that indicated that participants were speaking from personal experience. Several pointed out that it is important to listen:

'They [friends] wouldn't take you anywhere but they would speak to you, they would listen to you, you'd work off each other.' (gp3)

This speaker appears to be sharing an insight from his own experience of being supported by friends, and perhaps implies that the benefit can be reciprocal.

Another participant argued that friends need to be careful, and know someone well before attempting to support them:

'You have to know someone before you can help them otherwise you might make it worse.' (gp5)

Generally participants demonstrated recognition that mental health problems can be complex to deal with and that – depending on the severity of the problem – professional expertise may well be needed.

Interestingly, several participants focussed on helping with practical issues as well as the mental health issues. For example:

‘First it is important to find out the root of the problem – if it is psychological then you would try and make him hopeful. If it is economic, you help as much as you can.’
(gp4)

This was also evident in the suggestion that other professionals should be accessed who can directly address the difficult circumstances. This approach is in line with the view expressed earlier about the causes of mental health problems amongst asylum seekers and refugees – that the problems are fundamentally circumstantial rather than psychological in origin.

3.3.4. ‘Self Help’ Strategies

The focus groups were closed with a discussion of what someone who was ‘distressed, anxious or sad’ could do to help themselves or make their lives better. Again, participants displayed considerable insight on this topic and were able to suggest a range of appropriate strategies. This data is in contrast to the findings of the earlier Sanctuary study where participants demonstrated low levels of ‘emotional literacy’ and a lack of awareness of how to protect and improve their own mental health and well-being (Quinn, 2013).

Several of the groups discussed the balance between seeking help and trying to sort out problems yourself. Views ranged between arguing that it is better to handle problems yourself if possible, and recommending that people should go for help as it is not possible to sort out mental health problems alone. This spectrum was reflected in participants’ observations of others, ‘Some people don’t accept help’. (gp4). Generally there was a recognition that,

‘Everybody has their own means of letting it out, their own approach. Everybody has their own way of dealing with it.’(gp7)

There were two main themes in the strategies proposed for self-help:

- Being active and busy
- Getting connected with people and society

Participants suggested that pursuing an interest or activity is very helpful in taking your attention away from your problems. They recognised that a whole variety of activities could

fulfill this aim. Many said that they themselves played computer games or watched television. They recognised that this was a way to escape the problems:

‘I try not to think about my problem. I escape from the problem, I play with my computer games you know.’ (gp5)

However it does not itself help to solve problems:

‘... although sometimes it [internet] makes you busy and stops you from going forward and getting involved in other things. So it’s good and bad.’ (gp1)

Others recommended playing sport, going to the gym, going for a walk.

The second main theme was to advise that refugees or asylum seekers should, ‘Find some way to connect with new society.’ (gp2) It was recognised that making connections with people would generally make you happier, but to do that you would need to learn English and learn to understand the new society that you are living in. One participant suggested that:

‘People who go to a mosque or a church are generally happier because they are involved in community.’ (gp3)

In the same group another person pointed out that:

‘It’s good to have lots of different friends so that they can give you different kinds of help and support.’ (gp3)

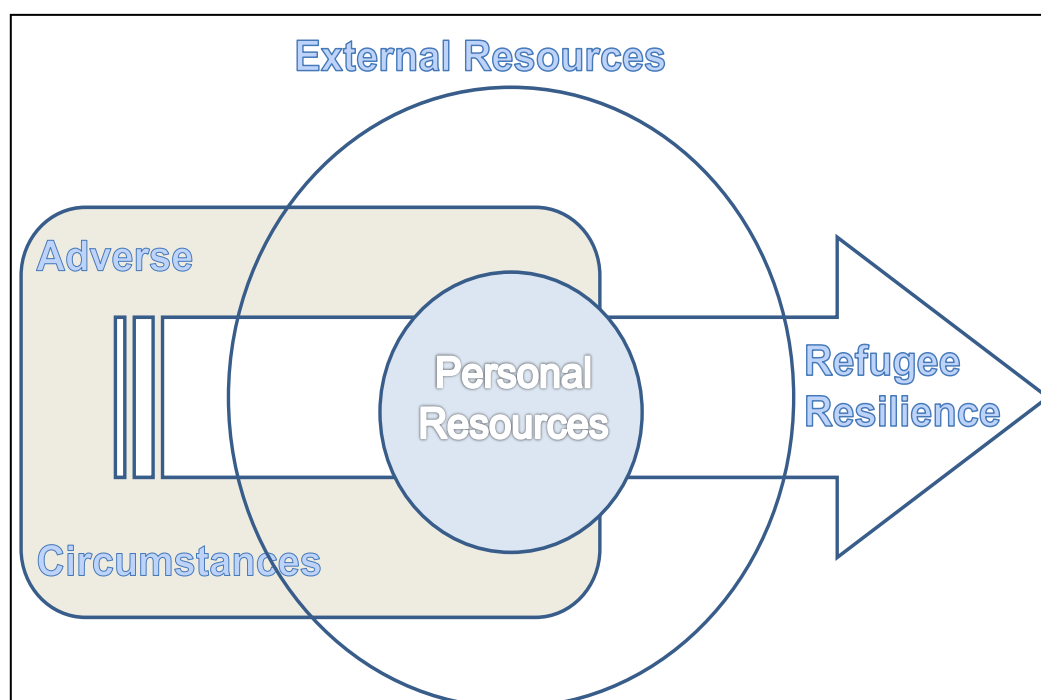
Participants generally agreed that it is helpful to have friends that you can trust, and spend time with.

4. Key Findings and Implications

In this study we have accessed some of the most isolated refugees and asylum seekers in Glasgow. This was only achieved through a very active partnership with the housing provider with whom we were able to visit refugees in their homes and invite them to participate. As anticipated, some of these single Afghan and Iranian men were very reluctant to engage with any agency including ourselves. However due to the participatory nature of the research design those who did attend the workshops were able to exchange information, sign up for college courses and some received referrals to other agencies.

Participants have described the toxic mix of adverse circumstances that undermine their mental health and well-being. At the same time we can also see much evidence of individual and collective resilience. The data suggests that these refugees are active in protecting and promoting their well-being as much as they can by keeping busy, trying to make friends amongst other refugees and wider Scottish society and supporting one another. However the emerging patterns of connections demonstrate the degree of isolation experienced by these men. The 'maps' provide an indication of strategic connections upon whom these refugees and asylum seekers must inevitably depend to access external resources. The 'maps' give an insight into the most acute gaps and suggest ways that the existing resources for promoting mental health and well-being for refugees in Scotland might be further mobilised and developed.

Figure 16: Refugee Resilience



4.1. Key issues emerging

4.1.1. Adverse Circumstances

This group are facing (and have probably already endured) huge life challenges and pressures. Yet participants see the main threat to their mental well-being as the adverse circumstances in which they find themselves.²⁹ Specifically they suggest that poor mental health is caused by:

- The chronic conditions of insecurity and instability under which they live. These participants experience uncertainty during their asylum claim itself. Their housing situation often continues to be unstable after receiving refugee status. Many are very anxious about the security of loved ones either back in their country of origin or whilst applying for asylum in UK.
- The experience of major life transition leading to ‘culture shock’. These participants described how disempowering it is to find yourself in a situation where everything is unfamiliar and you can’t even speak the language to start to explain yourself, ask questions or form relationships.
- Poverty creates practical problems, inhibits strategies for problem resolution and exacerbates isolation.

Implications: Our understanding of the causes of mental health problems has fundamental implications for how to address these problems and also how to build resilience and attempt prevention. This data suggests that access to advice and support in tackling the whole range of practical challenges facing asylum seekers and refugees is likely, in itself, to improve mental health and prevent problems from developing. Anticipating and preventing crises is crucial for the protection of mental health and well-being. It is essential that policy makers respond to the structural issues that result in poor mental health: the insecurity created by the asylum process, the disruption of being required to move house multiple times during and after the asylum seeking process, and the direct exclusionary effects of poverty. There is also a need to develop appropriate therapeutic interventions for specific mental health problems ensuring that these are addressed in the context of an individual’s particular circumstances as an asylum seeker or refugee. However, simply providing treatment without addressing the structural causes individualises a collective problem.

²⁹ Many other studies have similarly observed that the circumstances of resettlement play at least as much, if not a more major part than pre-flight trauma in refugee mental health and well-being (e.g. Silove et al., 2000; Watters, 2010)

4.1.2. Inactivity

These refugees and asylum seekers identify inactivity as one of the key exacerbating factors undermining coping and maintaining good mental health. They recognise that it is very hard to maintain mental well-being when you have, '...nothing to think about but your worries'. Even solitary, sedentary occupations such as watching TV or playing computer games were seen as better than having nothing else to think about. However getting out of the flat, taking exercise and meeting friends were seen as better. Some suggested that they could not participate in social events at any distance because of the cost of transport.

Implications: It is clear from the 'map' of resources produced by our stakeholder group that there is a large range of both formal and informal resources that isolated people could engage with in Glasgow. The lack of engagement seems to stem from a mixture of lack of knowledge, lack of money (for transport as well as entrance/membership fees) and lack of confidence or trust. Service providers need to consider how to overcome these barriers and ensure better access to services for refugees and asylum seekers. Once someone begins to stay in their flat and away from others it becomes harder to get out and get involved. Refugee community groups advising us suggested that asylum seekers and new refugees actually have a lot of appointments to attend as part of their pursuit of their asylum claim. Often these get in the way of engaging with other activities such as language or other college courses, and they certainly don't fulfil the function of distracting people from their worries.

4.1.3. Lack of intimate relationships

This group showed an awareness that they need intimate relationships for emotional support, yet most are without local access to family. Access to family through phone or internet connection is very important to many, but cannot provide an adequate substitute for sharing daily life. Some are clearly successful in developing close 'bonding' friendships (become like 'brothers') through which they are able to give and receive emotional support. Others are not successful even when they have been in Glasgow for several years. It appears that time alone is not sufficient to enable all refugees to develop supportive intimate relationships. For some isolated individuals, service providers themselves may (unknowingly?) be the main source of emotional support, leading to a relationship of dependency that is neither good for well-being nor sustainable.

Implications: Most asylum seekers and refugees would benefit if all formal and informal services purposefully combined the provision of their service with prioritising the 'development of positive and sustainable 'bonding' relationships'. The wider use of 'peer

support' mechanisms would be of particular value to those lacking in confidence to make personal relationships.

4.1.4. Lack of opportunity for reciprocity

Opportunities for reciprocal relationships are very limited for most of this group. They are occasionally able to help a few friends – mostly from the same background – and rarely help Scottish friends. In all other relationships the help-giving is unidirectional. This lack of balance leads to a sense of dependency and lack of opportunity for altruism which in itself is undermining to self-esteem and mental well-being. This adversely affects the individual, but also the way in which refugees and asylum seekers are perceived by society as a whole.

Implications: Many organisations do try to offer opportunities for volunteering, and clearly some asylum seekers and refugees take full advantage and get involved. However, there need to be specific strategies to draw in those who are lacking in confidence, or feel that they don't have any skills to offer or have poor English language skills. This data underlines the potential strategic role of community groups (particularly those which involve established as well as new communities) in providing informal opportunities for refugees and asylum seekers to contribute. As we saw, trust cannot be built quickly and is likely to depend on interpersonal contact. Once someone has become isolated, it is much harder to involve them again.

4.1.5. Developing a range of social connections

This group of refugees recognised the importance of connecting with people, and some pointed out that it is important to be connected with a range of different people, not only for emotional support and company, but also for access to services. They expressed an expectation that friends would be the natural source on information about services. This suggests that these refugees are motivated to develop a range of social connections. Yet the gaps that we have seen in their connections; including lack of family, friendships with Scottish people, knowledge about services and wider society demonstrate that significant barriers exist to achieving this aim. It was clear that time alone is not enough to develop either numbers or range of connections. Membership of community groups can support the development of some relationships (for example with people from the same country or people of the same religion), but this does not guarantee a mixture of 'bonds', 'bridges' and 'links'.

Implications: Refugee community organisations and other community groups are potentially very strategic in creating opportunities to support the development of a full range of social connections. This data underlines the importance of ensuring that:

- community groups are open and inclusive,
- members are sufficiently informed about resources beyond themselves to act as effective conduits of knowledge,
- community groups bring new migrants and the established Scottish population together.

4.1.6. Awareness of services

Awareness of services amongst participants in this study is lower than might be expected – including awareness of mental health support and advice services. Generally they either did not have access to extensive informal networks through which to learn about support, or their networks appeared to be detached from wider support services. They did however talk about using the internet to access information.

Implications: The data seems to suggest that either the participants do not see available services as relevant to their needs and/or they are not aware of the existence of certain services. Given the crucial role of informal networks in sharing information, this might point to the use of some form of peer advocacy to mobilise existing connections. Also more attention could be paid to strategic signposting. The data indicates that certain voluntary sector organisations and community groups will be perceived as a trusted source of information. It also indicates that some private sector organisations – such as shops – might be mobilised to reach isolated people. Asylum seekers and refugees often rely on the internet for information, which suggests that improving the design and accessibility of on-line information with their needs in mind could have significant impact. This would need to be prioritised along with improving free access to the internet and training in information technology skills.

4.1.7. Trust and fear of engagement

This group of single Afghan and Iranian refugee men were very reluctant to engage with the research workshops (even though the team were introduced by the housing provider) suggesting that they might also be resistant to engagement with other community activities and services. Of those that did engage they reported highest levels of trust in authority figures (Police, lawyers) and formal support services (GPs, case workers, social services). There was a lack of engagement in third sector agencies and community organisations.

Implications: Reluctance to engage with any outsider will inevitably lead to isolation and reduce access to both informal and formal support. There are good levels of trust for a few organisations but low levels of trust for most. Could the trust that does exist be mobilised to focus signposting to other agencies? The data suggests that service providers need to work

on establishing trust with refugee communities. One-to-one peer mentoring or ‘buddying’ schemes would help by establishing a relationship of trust through which others can be fostered. A possible way forward may be for agencies to hold specific events for refugees in partnership with refugee community organisations, based on the seminar model developed by the Scottish Refugee Council³⁰.

4.1.8. Access to Rights

This group showed very little awareness of institutions in wider UK society. They did not demonstrate awareness of routes through which they might challenge decisions or quality of service provision (for example regarding housing or health care).

Implications: Access to rights depends on confidence as well as knowledge – both of which are lacking amongst isolated asylum seekers and refugees. Whilst it would be very difficult to empower the most vulnerable individuals directly, this does once again reinforce the importance of investing in the support of refugee community organisations and other community groups to enable them to act both as conduits of information as well as advocates for rights. Given the low levels of engagement with advice agencies such as CAB and law centres, there needs to be a focus on signposting to these sources of support.

³⁰ Scottish Refugee Council, Holistic Integration Service 2013- 2016.

4.2 Recommendations for policy & practice

We suggest that in order to protect and promote the mental health and well-being of asylum seekers and refugees in Glasgow policy makers and practitioners should:

Recommendations

- **Address the causes of insecurity and instability, (uncertainty of asylum claims, family reunion and poverty).**
- **Provide support and accompaniment to asylum seekers and refugees in tackling practical problems.**
- **Support every asylum seeker and refugee to develop intimate and reciprocal friendships.**
- **Work through trusted people and organisations to signpost information and build engagement with wider resources and services.**

The findings and conclusions of this study have been shared and discussed with a range of stakeholders in Glasgow (Appendix 5). The following recommendations emerged through consultation:

➤ **Address the causes of insecurity and instability**

- Directly address causes of insecurity and instability through **policy advocacy** on: the asylum process, transition to new refugee status, and family reunification.
- Avoid unnecessary destabilisation by **minimising home moving** through enabling asylum seekers to remain in the same property on receipt of status.
- Avoid unnecessary destabilisation by ensuring that refugees have access to **sustainable housing options within 28 days** of receiving status.
- The **Poverty Leadership Panel's Action Plan** should reflect the experience of asylum seekers and refugees, given that one of the key priorities is to involve people with direct experience of poverty.
- Poverty acts as very real barrier to good health and well-being, engaging with activities, other people and services – services need to build in **capacity to overcome poverty** (e.g. waiving membership or attendance fees, providing travel expenses), community groups should be encouraged to avoid or share participation costs.

- **Improve access and knowledge of free activities** (e.g. libraries, museums, sports facilities).
- **Provide support and accompaniment to asylum seekers and refugees in tackling practical problems**
- Strengthen support through **advisory services** (Migrant Help, Glasgow's Advice and Information Network (GAIN³¹))
 - Extend **peer mentoring schemes** so that a mentor is available for every person who wishes one.
 - To support them through transition, asylum seekers and refugees need **immediate access to language** learning support on arrival in the country.
 - Language courses should build in the direct development of **cultural knowledge** and help participants to learn local colloquial uses of language.
 - Building on the work of the 'Sanctuary' staff training³², acknowledge that these adverse circumstances are undermining for mental health and well-being and provide **training for mental health practitioners** and other front-line service providers to ensure that they are aware of the pressures affecting asylum seekers and refugees.
- **Support every asylum seeker and refugee to develop intimate and reciprocal friendships**
- Language teaching providers should try to **create social opportunities** for service users. Language courses should strategically **support the opportunity to develop friendships**, for example through the 'Languages café' model³³.
 - **Housing providers** can play a crucial role in preventing isolation. Housing Officers, Concierges, and other case workers provide a unique means of communication and link between individual refugees and community groups and services. Records enabling the identification of new refugees would facilitate outreach to those who have become withdrawn and reluctant to engage.
 - Buddying, peer mentoring, accompanying should be extended to ensure that every asylum seeker/refugee has the opportunity for linking into a **one-to-one relationship** with someone who can help them to navigate their new lives (for as long as is needed). Ideally they should start with someone of own language group and transition to someone from Scottish background (e.g. scheme for early retired people?).

³¹GAIN: <http://www.gain4u.org.uk/>

³²<http://www.mwscot.org.uk/media/186818/sanctuary.pdf>

³³<http://www.languagecafe.eu/en/intro.html>

- Community planning partnerships should support community integration initiatives (through refugee community organisations and other community groups) in **building relationships between** new and established refugees and across people with Scottish and other backgrounds.
- Service providers and community groups should build in opportunities for **volunteering** wherever possible. In particular there is a need for more opportunities that don't require confidence or particular skills and language in order to widen access to volunteering and draw on the rich experience asylum seekers and refugees have to offer.

➤ **Work through trusted people and organisations to signpost information and build engagement with wider resources and services.**

- Service providers should ensure that welcome packs and other basic service information are up-to-date, relevant and made **available at time of need and recognition** of relevance (and be available in an appropriate range of languages).
- A good quality, confidential **interpretation service** with sufficient capacity will continue to be essential to ensure equitable access to services and rights.
- Policy makers and service providers should develop **clear pathways in to and out of services** based on an understanding of the integration journey.
- Service providers should provide **staff training** on how to engage with asylum seekers and refugees in culturally appropriate ways and how to signpost and/or refer to other services, building on the Sanctuary training³⁴ for front-line staff.
- Service providers should ensure key **people and places that are already trusted** and act as conduits for information and connection should be mobilised to share information. For example certain shops, colleges, libraries. Develop community knowledge about services and rights by disseminating information about rights through refugee community organisations, community seminars (such as the SRC programme³⁵) and peer educators.
- Service providers should **use the internet more strategically**, ensuring information, navigation and application processes are provided in an accessible manner using different languages as appropriate.
- Further Education Colleges should maintain and **improve access to the internet** through access to computers on-line and access to IT skills.

³⁴ <http://www.mwscot.org.uk/media/186818/sanctuary.pdf>

³⁵ <http://www.scottishrefugeecouncil.org.uk/>

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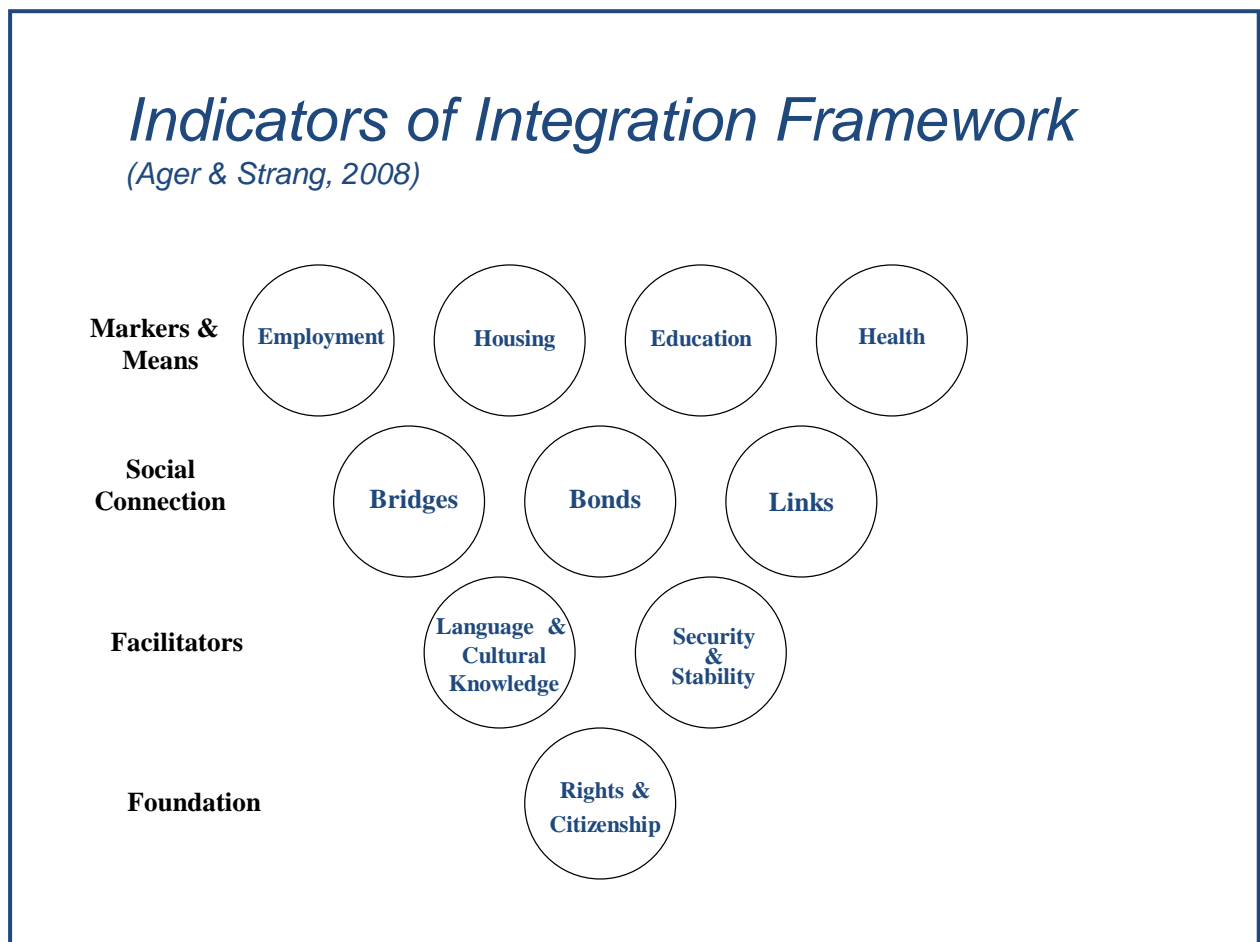
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Appendix

APPENDIX 1: Indicators of Integration Framework

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Journal of Refugee Studies, 21 (2):166–91.



APPENDIX 2:

Sample Information Sheet



An opportunity to meet other local people and learn about local services Please join us!

This event is for you if you are,

- A man over the age of 18 years
- You originally came from Afghanistan or Iran
- You have come to Glasgow as a refugee

Wed 27th February, 11.30 – 2.00pm

TOWNHEAD COMMUNITY HALL

7 ST MUNGO PLACE

G4 OPB

A light lunch will be provided

The meeting will provide an opportunity to meet others and learn more about local opportunities and services here in Glasgow.

It is part of a research study (run by NHS Greater Glasgow and Clyde and Queen Margaret University, Edinburgh) to explore social connections and refugees mental health in north and east Glasgow. There is a concern that many refugees feel very isolated and this damages their mental health and their ability to make a new life in Scotland. We would like to meet men who do not feel isolated and also those who do feel isolated. There are two important aims of this study:

AIMS: 1) That all participants will enjoy participating in the event, meet new people and learn more about useful local opportunities and services.

2) That we – the housing providers and the research team – will learn more about how to support refugees more effectively as they adapt to life in Scotland. (The results of the study will be shared with local service providers to help inform what type of services they need to provide in the future and may be published in a journal or presented at a conference)

If you agree to participate in this study we will:

- Visit you at home very briefly (about 10 minutes) and ask you to complete a short questionnaire about how many people you meet in your normal life at the moment

- Ask you to attend a meeting near your home (lasting about 2 and half hours) and join in some group activities, individual activities and some discussion together. The meeting will be led by a research team, supported by interpreters (these may include both men and women). All information collected will be anonymous and will be stored securely and then destroyed once the research is complete. The groups will each develop a 'maps' of local support and these will be left with project workers to use in any way that is helpful to the community.

The research team will *not* be able to advise or help with anyone's personal circumstances, but will share information about support services. Joining in the study will not harm or benefit your access to rights or services.

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact Elodie Mignard, Housing Development Officer, Scottish Refugee Council. Contact details are given below.

Independent adviser: Elodie Mignard
Housing Development Officer
Scottish Refugee Council

elodie.mignard@scottishrefugeecouncil.org.uk

Researcher: Dr Alison B Strang
Senior Research Fellow
Institute for International Health and
Development, Queen Margaret University,
Edinburgh EH21 6UU
astrang@qmu.ac.uk

APPENDIX 3: Interpreter Briefing Sheet



Queen Margaret University
EDINBURGH



NHS GREATER GLASGOW & CLYDE AND QUEEN MARGARET UNIVERSITY REFUGEE SOCIAL CONNECTIONS STUDY, FEB/MARCH 2013

Many refugees feel very isolated and this damages their mental health and their ability to make a new life in Scotland. This study is part of a research programme (run by NHS Greater Glasgow and Clyde and Queen Margaret University, Edinburgh) to explore social connections and refugees mental health in north and east Glasgow. We would like to meet refugee men from Afghanistan and Iran including those who do not feel isolated and also those who do feel isolated. There are two important aims of this study:

AIMS:

- 1) That all participants will enjoy participating in the event, meet new people and learn more about useful local opportunities and services.
- 2) That we – the housing providers and the research team – will learn more about how to support refugees more effectively as they adapt to life in Scotland. (The results of the study will be shared with local service providers to help inform what type of services they need to provide in the future and may be published in a journal or presented at a conference)

Phases of the Study:

- 1) Housing association staff, researchers and interpreters visit tenants to introduce study, seek consent and ask initial questions
Monday 18th Feb
- 2) Data collection workshops:

Mon 18th February 1 – 3.00pm

TOWNHEAD COMMUNITY HALL
7 ST MUNGO PLACE

Tues 26th February, 1.30 – 4.00pm

ST ROLLOX CHURCH
9 Fountainwell Road
Glasgow, G21 1TN

Wed 27th February, 11.30 –

2.00pm
TOWNHEAD COMMUNITY HALL
7 ST MUNGO PLACE

Principles for interpreting:

1. Participants may be very emotionally vulnerable and therefore it is essential that all information shared during this process is kept confidential.
2. In this study we will be interested in the exact words that participants use to discuss the questions that we raise, and so will ask for direct translations of what is said (both by us the researchers and by participants) wherever possible. We will discuss key words together before the data collection workshops. If there is any ambiguity, please speak with a member of the research team.

Neil Quinn and Alison Strang

APPENDIX 4: Registration Questions



Queen Margaret University
EDINBURGH



Social Connection and Refugee Mental Health in North and East Glasgow

Thank you for agreeing to participate in this study. It would help us to prepare for the meeting if you could answer a few questions about your life here now. This information will not be shared with anyone else outside the research team, will not affect any of your rights and will be destroyed after the meeting. You don't need to answer any of the questions if you would prefer not to.

1. How many people live with you in this flat?
2. How long have you lived in Glasgow?
3. How long have you lived at this address?
4. How old are you?
5. What is your first language?
6. How confident are you in using English? Response options: not able to converse(1)/not very (2)confident/confident(3)
7. Would it help you if we provide an interpreter to support your participation in the event?

We are finding out how many people participants meet from day to day, could you tell me:

8. How many people – including those who live with you – did you speak to yesterday either face to face, on the phone, through Skype?
9. Let's think about last Friday (three days ago): How many people – including those who live with you – did you speak to last Friday either face to face, on the phone, through Skype?
10. Finally, let's think about six days ago - last Tuesday: How many people – including those who live with you – did you speak to last Tuesday either face to face, on the phone, through Skype?

Thank you for your help.

APPENDIX 5: Attendees at final stakeholders' conference

Ann Forsyth	NHS
Catherine Shields	Social Work
Christine Palmer	City of Glasgow College
Jacqueline Murray	Greater Glasgow Police - Safer Communities
Holly Bear	COMPASS
Janet Hayes	NHS
Janice Mitchell	NHS
Jim Battersby	Glasgow Housing Association
Marlyn Barr	Glasgow Kelvin College
Mary Kate Dickie	Scottish Refugee Council
Mary McManus	City of Glasgow College
Muriel Pearson	Cranhill Community Church
Phil Arnold	Red Cross Refugee Unit
Rosaline Martin	EAL – Glasgow City Council
Selam (MSc student)	COMPASS
Tony Devine	Health Improvement
Wendy Gormley	Glasgow Kelvin College
Aso Fotoohi	Scottish Refugee Council
Maureen Morris	PMA Steering Group
Robert Aldrige	Homeless Action Scotland
John Mason	MSP